HEALTH DISCIPLINES BOARD INVESTIGATION OF MIDWIFERY

FINAL REPORT AND RECOMMENDATIONS

ALBERTA HEALTH DISCIPLINES BOARD
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BACKGROUND

In 1982, the Alberta Council and Register of Domiciliary Midwives Association (ACRDMA) applied to the Health Disciplines Board for designation of domiciliary midwifery under the Health Disciplines Act. The Board recommended against designation on the grounds that domiciliary midwifery is a subset of the larger occupation of midwifery in all settings, and the Board believed it was not in the public interest to partition this discipline. However, the Board added that this "recommendation should not be seen to bias an investigation of the total occupation of midwifery if an application (for designation) is ever received."[1]

In 1986, the ACRDMA and the Western Nurse-Midwives Association merged to form the Alberta Association of Midwives (AAM). Subsequently, in August, 1989, the AAM applied to the Board for designation of the total discipline of midwifery.

THE BOARD'S INVESTIGATION

The Board began its investigation of midwifery in April, 1990. Over the course of this investigation, the Board invited 107 organizations to submit written briefs on midwifery; 62 of these organizations responded. In addition, individual citizens were invited (by way of newspaper advertisements) to submit letters to the Board outlining their views on midwifery; 242 letters were submitted.

The Board concluded the investigation by hearing oral presentations from 14 of the organizations that submitted written briefs, and four of the individuals who submitted letters.

The Board is grateful for the participation of all the organizations and individuals who contributed to this investigation, and for the invaluable information and advice they provided.

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[1]Alberta Health Occupations Board, Report on the Final Results of the Investigation of the Occupation of Domiciliary Midwifery (Edmonton, 1983), p. 44.

ISSUES AND RECOMMENDATIONS

Midwifery is a recognized, regulated discipline in 202 of the 210 member nations of the World Health Organization, including the United States and all European countries. Although Canada appears to be out of step with other Western nations in this regard, movement toward the recognition of midwifery has been gathering momentum in several Canadian provinces (particularly in Ontario, where a Midwifery Act was introduced late last year, and in Quebec and British Columbia).

This movement reflects increasing public demand for more responsibility and choice in health care services, including maternity care. Midwives and their supporters argue that many women have become disenchanted with what they regard as highly technical and often needlessly intrusive obstetrical services. Instead, these women seek care which treats childbirth as a natural process, and gives them greater responsibility for decisions affecting pregnancy, labour and delivery. They believe midwifery care is a safe alternative that can help make childbirth more satisfying for themselves and more gentle for their babies.

Supporters of midwifery have pointed out that these beliefs about the need for change and choice in maternity care are in step with the principles presented in the Rainbow Report published by the Premier's Commission on Future Health Care for Albertans:

> " We believe in people being the focus of the health system; in free and voluntary choice (and) personal responsibility; ... in the inevitability and desirability of change ...; in health decisions which are most effective and least intrusive; and in making the opportunity available to all Albertans to maximize their own health."

They are also in step with a fundamental objective of the Government as stated in its Principles and Policies Governing Professional Legislation in Alberta:

> "... (professional legislation should) enable service users to exercise informed judgement and freedom of choice with respect to professional services."

Risk to the Public

There was a virtual consensus among organizations which submitted briefs and individuals who submitted letters to this investigation that the risks inherent in midwifery practice warrant regulation

through professional legislation. After completing its investigation, the Board agrees that this is the case and, therefore, recommends that

> **the degree of risk associated with the practice of midwifery is such that the discipline should be designated under the Health Disciplines Act.**

The Board also acknowledges that several of the organizations stating support for (or acceptance of) legislative recognition of midwives attached certain conditions to their support, and that some of these conditions conflict with what the AAM and its supporters have requested. Three major conditions were identified:

1) that a need for midwives services (beyond the obstetrical services that already exist) be demonstrated;
2) that only practitioners trained as registered nurses be allowed to practise as midwives, and that midwives be governed under the Nursing Profession Act; and
3) that midwives not be allowed to attend planned home births.

Although the Board's primary mandate is to recommend designation if the risk to the public warrants regulation, it also addressed these three issues.

Need for Midwifery Services

The College of Physicians and Surgeons of Alberta, the Alberta Society of Obstetricians and Gynaecologists, and the College of Family Physicians of Canada (Alberta Chapter) all stated that a need for midwives' services should be demonstrated before midwifery receives legislative recognition.

The Board agrees this is a reasonable expectation; designation of midwifery would serve little purpose if there is not an appreciable need or demand for midwives' services. However, the Board reviewed a great deal of information (in briefs, presentations and, in particular, letters from individual citizens) which reflected dissatisfaction with existing obstetrical services, and a strong desire that health care consumers be allowed to choose midwifery services. All but four (238 of 242) letters expressed strong support for legislative recognition of midwives. After reviewing this information, the Board believes there is sufficient need and demand to warrant designation. However, it also believes the full extent of the need and demand for midwives' services, and the level of service required to meet these needs, would become fully apparent only after the designation of midwifery and its integration into the health care system.

Educational Preparation

The Board believes that midwifery practice in Alberta must be based on excellent educational preparation to ensure public protection. It therefore considered carefully the view that midwives should in all cases have a registered nurse qualification in order to register and practise. However, many of the jurisdictions which regulate the practice of midwifery offer and recognize both nurse and non-nurse midwifery training. The Province of Ontario is planning to establish a baccalaureate program leading to a degree in midwifery which would be open to both nurses and non-nurses. The Board noted that training programs for registered nurses and midwives may include many of the same subjects of study, and that nursing can be an excellent basis for midwifery training and practice. However, it believes that both routes of training should be recognized as acceptable for registration as a midwife in Alberta, provided the specific programs meet an acceptable standard of excellence. Therefore, the Board recommends that

> **registration as a midwife under the Health Disciplines Act should not be restricted to individuals who have a registered nursing qualification.**

On the question of which legislative mechanism should be used to regulate midwifery practice, a number of stakeholders (the Alberta Association of Registered Nurses (AARN), the physicians' associations, and the Alberta Hospital Association (AHA)) argued that midwives would more appropriately be regulated under the Nursing Profession Act and governed by the AARN.

In considering this argument, the Board noted that most current AAM members have nursing backgrounds, and that the practices of midwifery and nursing share several features in common. However, a number of stakeholders (including Alberta Health, Alberta Career Development and Employment and the AAM) believe the Health Disciplines Act is a more appropriate mechanism for regulating midwives. The AAM and its supporters, in particular, are strongly opposed to regulation under the Nursing Profession Act. They believe midwifery is qualitatively different from nursing and fear it may lose this distinctiveness if it is governed by the AARN. Indeed, the AAM has requested that midwifery should as far as possible be an autonomous, self-regulating discipline, and that midwives must play a central role in developing and enforcing their own standards of practice and rules of conduct.

The Board believes the Health Disciplines Act is uniquely appropriate legislation for the implementation and regulation of midwifery. The Act allows for an appropriate degree of self-governance by midwives while also enabling other health care stakeholders to participate fully in the development of midwifery standards and regulatory processes. It makes provision for the establishment of a multi-disciplinary Implementation Advisory

Committee and for two different mechanisms for governance of the discipline. Firstly, midwifery may be governed by a "health discipline committee" which would include representatives from the AAM and other health care organizations. However, if midwives demonstrate a willingness and capacity to govern the discipline more autonomously, the Act allows for self-governance by their "health discipline association."

The Board believes it is essential that physicians, nurses and hospital administrators (among others) be directly involved in the development of midwifery standards and in the initial governance of the discipline, at least until midwives become well-established and widely-accepted throughout the health care system. Therefore, it recommends that

> **a Midwifery Implementation Advisory Committee, which includes representation from the Alberta Association of Midwives, the College of Physicians and Surgeons, the Alberta Association of Registered Nurses, the Alberta Hospital Association and the public, be established to advise the Board on implementation issues.**

The primary focus of this Advisory Committee would be the development of regulations governing the scope and practice of midwifery in Alberta. This Committee would also advise the Board on matters such as which nurse and non-nurse educational programs should be recognized as qualifications for registration in Alberta.

Home Births

Midwives' attendance at planned home births has been the most prominent and contentious issue in this investigation. All the physicians' associations that submitted briefs are opposed to home births because they feel childbirth at home is inherently more dangerous for both women and their babies than childbirth in hospital.[2] Consequently, they argue that midwives should provide care during labour and delivery only in hospitals (and, perhaps, related birthing centres) under the authority of physicians and in concert with nurses and other health care personnel.

The AAM and all of the other supporters of midwifery contend that giving birth at home is a safe alternative to giving birth in hospital for women who are carefully selected (i.e., judged to have

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[2]Although initially opposed to midwives attending planned home births, the AARN in its oral presentation before the Board indicated that it has changed its position; it is receptive to the idea of midwives attending planned home births provided the public is prepared to accept the risks and midwives who attend them are properly trained and regulated.

low-risk pregnancies) and properly attended. Therefore, the AAM feels that trained, competent midwives should be allowed to attend home births.

The Board reviewed a great deal of information on the relative safety of the home and hospital as settings for childbirth. In addition, the Board commissioned a national consulting firm to review and draw a conclusion from research literature on this topic published during the last five years. The consultant used as starting points the conclusions of two recent, extensive literature reviews on this subject published in the Report of the Ontario Task Force on the Implementation of Midwifery (1987) and the British Journal of Obstetrics and Gynaecology (1986). The consultant arrived at the same conclusion presented in the two previous reviews - that there is no conclusive evidence to support the view that giving birth at home is significantly less safe than giving birth in a hospital for carefully selected and properly attended women.[3] Without such evidence, the Board feels it is difficult to justify restricting the right of women to receive intrapartum care in their homes from trained, competent midwives, and the right of trained, competent midwives to provide this care.

The Board does acknowledge that there are potential risks associated with home births. However, it believes that these risks could be substantially reduced by ensuring that birth attendants are properly qualified, that criteria and procedures for conducting home births are defined and adhered to, and that back-up medical services (from physicians and hospitals) are pre-arranged.

Most important in the Board's deliberations is the realization that home births will continue to occur whether or not legal provision is made for qualified midwives to attend them. The home birth advocates who presented their views to the Board appeared to be educated, knowledgeable, well-meaning people who deeply believe they have a right to determine whether home birth is in the best interests of themselves, their babies and their families. The Board is certain that, if only hospital-based midwifery services were to be recognized and regulated, many of these women would still choose to give birth at home. If qualified, registered midwives are prohibited from attending home births, the risks facing women who choose to give birth at home will increase. Such a consequence may undermine the purpose of establishing standards and regulating midwives' services.

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[3]Each of these reviews point out, however, that research on this topic has been plagued by methodological problems, and presents data that may be relevant only to the particular jurisdiction (i.e., system of obstetrical and midwifery care) from which they were drawn.

Therefore, the Board recommends that

> **home births be included in the scope of practice of midwifery.**

However, recognizing the risks associated with home births, the Board further recommends that

> **the Midwifery Implementation Advisory Committee advise the Board on conditions and restrictions to be required for midwives' attendance at planned home births, taking into account risk, experience, and access to medical support services.**

CONCLUDING REMARKS

Incorporating midwifery into Alberta's health care system would be a challenging task and many implementation issues would have to be addressed and resolved. These include the development of appropriate and effective standards, midwives' relationships with other health care personnel, cost implications and whether additional Alberta-based midwifery training will be needed.

However, as the Alberta Medical Association stated in its oral presentation, the nature of obstetrical services in Alberta (and the outlook of those who provide them) is changing to serve citizens better. The Board hopes and believes that, if the Government decides to designate midwifery, all health care groups will work together to address and resolve these issues, and to ensure that the people of Alberta have access to safe, effective midwifery care.

PREAMBLE

In a letter dated August 22, 1989, the Alberta Association of Midwives (AAM) formally requested that midwifery be designated under the Health Disciplines Act. This request prompted an investigation by the Health Disciplines Board to determine whether to recommend the designation of midwifery under the Act.

In carrying out investigations of health disciplines, the Board is required under Section 4(3) of the Act to ascertain with respect to the discipline or its practitioners:

(a) the tasks performed and their complexity;

(b) the degree of direction or supervision received by practitioners;

(c) the educational programs available in Alberta; and

(d) the educational programs available outside Alberta.

Further, in regard to the matters ascertained, section 4(4) of the Act requires the Board to:

(a) evaluate the degree of direct and personal impact practitioners have on the health of those whom they care for or treat;

(b) determine the health services practitioners may provide and any limitations or conditions applicable to the provision of those services;

(c) evaluate the extent of independence of practice that is necessary or desirable for practitioners;

(d) consider what qualifications with respect to education, training, specific knowledge or technical proficiency may be desirable for practitioners; and

(e) consider what may be the minimum standards of competency for practitioners.

The Board conducts its investigations of health disciplines in three stages:

1. The Board collects information about the health discipline by soliciting briefs from local, national and international organizations interested in, or knowledgeable about, the discipline. The Board also advertises in newspapers for submissions from individual citizens and reviews existing

literature on the discipline. This stage ends with the preparation of an interim report;

2. The Board considers all the information collected during the first stage and listens to oral presentations regarding the discipline from concerned organizations and individuals. This stage ends with the Board members voting on whether to recommend the designation of the health discipline; and

3. The Board prepares a final report which presents all the information considered in the investigation and the recommendation on designation and submits it to the Minister Responsible for Professions and Occupations.

This document is the final report; it is the culmination of the three stages of the investigations.

I. INTRODUCTION

The AAM formally requested on August 22, 1989 that midwifery be designated under the Health Disciplines Act. This was not the first such request concerning midwifery received by the Board; in June, 1982 the Alberta Council and Register of Domiciliary Midwives Association (ACRDMA) applied to have domiciliary midwifery designated under the Act. The Board carried out an investigation and recommended that domiciliary midwifery not be designated. Their decision was based on the fact that the ACRDMA did not represent all those in Alberta who professed to be midwives. Indeed, the Western Nurse Midwives Association was also established at that time and opposed designation. The Association wrote that it

> "would be supportive of designating the occupation of (midwifery) as a "designated health occupation", but not the occupation of domiciliary (midwifery) which is only one subset of the total occupation. Midwives, by tradition, provide services in childbirth in hospitals, clinics, health units and domiciliary settings. Thus, to register the occupation of domiciliary midwifery would not serve the needs of the public who may desire a midwife to attend (a) birth but ... not ... a home delivery."[1]

The Board's recommendation to Government expressed similar concerns:

> "... the occupation of domiciliary midwifery should not be a designated occupation under the Health Occupations (Disciplines) Act because domiciliary midwifery is a small subset of a larger occupation of midwifery. The Board does not believe that it is in the public interest to partition this occupation into several parts."

However, the Board also stated that

> "... this recommendation should not be seen to bias an investigation of the total occupation of midwifery if an application is ever received."[2]

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[1]Western Nurse Midwives Association, Brief on Domiciliary Midwifery Submitted to the Health Occupations Board, July, 1983.

[2]Alberta Health Occupations Board, Report on the Final Results of the Investigation of the Occupation of Domiciliary Midwifery (Edmonton, 1983), p. 44.

In 1986, the ACRDMA merged with the Western Nurse Midwives Association to form the AAM. The AAM is now made up of 73 members; 67 of them are nurse-midwives and the rest have some form of direct entry midwifery training.[3] Therefore, the present application by the AAM has been made on behalf of both these types of midwives for designation of the total discipline of midwifery.

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[3]Alberta Health, Brief on Midwifery Submitted to the Health Disciplines Board, October, 1990, p. 1.

II. DESCRIPTION OF THE INVESTIGATION

A. Requests for Briefs from Organizations

At the outset of this investigation, the Board compiled a list of organizations thought to be involved in, or knowledgeable about, midwifery. The list was comprised of midwives' associations, physicians' associations, allied health associations and regulatory bodies, educational programs and institutions, government departments both in and outside Alberta, and various other organizations concerned with midwifery. This initial list of organizations was reviewed and added to by the AAM and several other stakeholders.[4]

In all, 107 organizations were invited to submit written briefs. Sixty-two of these organizations responded, representing a response rate of 58%. An account of the organizations that responded is provided in Appendix 1: "Organizations Contacted and Responses Received in the Midwifery Investigation".

B. Request for Letters from Individual Citizens

The Board published an advertisement in eight daily newspapers on two dates (June 8 and 9, 1990) to advise the public that an investigation of midwifery was taking place. In the advertisement citizens were invited to submit letters to the Board (in care of the Registrar) outlining their views on midwifery and stating whether they supported the designation of midwifery under the Health Disciplines Act. Two hundred and forty-two letters were submitted to the Board.

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This report is a summary of all the information and views presented in the written briefs and letters, and other relevant literature collected by the Board. It consists of: a generally accepted definition of midwifery; selected remarks on the earliest forms of regulation of midwifery in the Western world; a short history of midwifery in Canada; a summary of the arguments for designating midwifery put forth in letters that individual citizens submitted to the Board; an overview of the different positions taken by

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[4]Each organization that was asked to submit a brief on midwifery also received a list of the organizations being contacted. They were invited to suggest other organizations the Board should contact for further information and views on midwifery.

responding organizations on the major issues pertaining to the recognition and regulation of midwifery; and information on current forms of regulation, training programs, scope of practice, standards of competency, and risks midwifery may pose to the public.

The final two sections of the report present a summary of the oral presentations made to the Board, and the Board's recommendations to Government concerning legislative recognition and regulation of midwifery.

Due to the unusually large number of responses and volume of information submitted to the Board, it would have been difficult to incorporate the views of particular Alberta organizations into each section of the report. Instead, an appendix has been added which outlines the positions of selected Alberta-based organizations (both government and non-government) on the major issues in this investigation (see Appendix 2: "Summaries of the Briefs of Selected Alberta Respondents").

III. DEFINITION

The definition of "midwife" endorsed by the Alberta Association of Midwives, the International Confederation of Midwives, the International Federation of Obstetricians and Gynaecologists, and the World Health Organization reads as follows:[5]

> "A midwife is a person who, having been regularly admitted to a midwifery educational programme duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery, and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.
>
> The midwife must be able to give the necessary supervision, care, and advice to a women during pregnancy, labour, and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.
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> The midwife has an important task in health counselling and education not only for patients, but also with the family and community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care."

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[5]Alberta Health, p. 2.

IV. HISTORICAL OVERVIEW

A. Beginnings of Regulation[6]

According to scholars who have studied the history of the discipline, midwifery in the Western world provides one of the oldest examples of professional regulation and professional competition.

During the Middle Ages midwifery was regulated, if at all, through the Church. However, by the mid-15th century, it was established practice for midwives in Continental Europe to be examined by members of the medical profession as to their methods and procedures. During this era midwives were expected to consult with barber surgeons, or male midwives, in the event of an emergency.[7]

During the 17th century, professional competition developed between female midwives who normally attended births, and male midwives who were called in to tend to difficult or complicated births. Male midwives often became involved to either remove a dead fetus in an attempt to save the mother, or to perform a cesarean section on a dead mother to save a fetus. The expertise of male midwives rested in their claim to the exclusive use of surgical instruments. The position of male midwives was greatly enhanced by the invention of forceps (in the early 1600s) that could increase the likelihood of delivering a live infant.

During this period, competition between male and female midwives could also be seen in regulatory issues. Following the Reformation, when midwives were licensed by the Church of England, two events occurred that foreshadowed modern concerns. In 1616, Peter Chamberlin petitioned James I "that some order may be settled by the state for the instruction and civil government of midwives." The petition was not successful. Later, in 1687, midwives suggested that a corporation of midwives be established but the College of Physicians of London opposed it.[8]

The trend in 19th century Europe was toward the professionalization and regulation of midwifery. For example, a college was

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[6]Alberta Health Occupations Board, p. 16.

[7]S. Romalis, An Overview in Childbirth: Alternatives to Medical Care (Austin, Texas, 1981).

[8]M.F. Myles, Textbook for Midwives, 9th Ed. (London, 1981), page unknown.

established in London in 1864 to train professional midwives, and in 1872 the Obstetrical Society of London constituted an examining board which issued certificates to candidates attesting to their competence to attend "normal births".[9] Today, midwifery remains an established and regulated profession in European countries. In contrast to the situation in Europe, however, childbirth in Canada was, over the years, almost completely taken over by the medical profession.

B. History of Midwifery in Canada[10]

"The story of midwifery ... in Canada ... is the story of a highly developed birth culture, surprisingly similar in both native and settler populations, that was gradually eclipsed by expanding medical control over childbirth."[11]

Midwifery has a long history in Quebec and Nova Scotia, where government-salaried midwives practised as far back as the early- and mid-1700s. Midwifery in these areas was legal until after the First World War. In Newfoundland, midwifery had such a long tradition in villages and outposts, in spite of not being explicitly permitted, that women were in active practice all over that province until the 1960s. Throughout Ontario and the West, women whose primary function was midwifery were rare; helping out at births was simply something that neighbours did for one another.

Throughout most of Canada, knowledge of childbirth seems to have been widespread and attitudes toward birth hopeful rather than fearful. Birth was a central event in the life of early communities; it had crucially important benefits both in strengthening family bonds and in establishing emotional links between groups of relative strangers as they began to form new communities. Because assisting at birth was so securely entwined with normal community life, midwifery was rarely a trade or a profession in itself. There may have been a woman in the community, always a mother herself, who had extra skill and experience and might be especially sought when a woman was in labour. However, such women seldom attended more than 60 to 90 births during their lifetimes.

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[9]M.F. Myles, page unknown.

[10]Ontario Task Force on the Implementation of Midwifery (Mary Eberts, Chairperson), Appendix 1 of the Report of the Task Force on the Implementation of Midwifery in Ontario (Toronto, 1987), pp. 197-227.

[11]Ontario Task Force on Implementation of Midwifery, p. 197.

The overriding theme of assisting at childbirth seems to have been that, whenever possible, familiar women (i.e., neighbours and relatives) should stay with the mother throughout the whole of her labour to comfort and encourage her. Other forms of support were also commonly provided. For example, gifts of food, clothing and housework were given to the households of childbearing women.

In terms of birthing techniques, the traditional approach was essentially non-interventionist. Childbirth was regarded as an entirely natural process and women appear to have interfered very little as they helped one another. An emphasis on providing a supportive, comforting environment was combined with a flexible attitude toward labour. For example, women were encouraged to walk and keep to their activities as long as possible during the first part of labour, and squatting seems to have been common during the pushing stages.

Historical accounts of this traditional birth culture suggest that it was, on the whole, very successful in the context of the time when it flourished; it did not subside until the period between the two world wars.

Why then was midwifery gradually overtaken by expanding medical control over childbirth? Several developments appear to have contributed to the progressive disappearance of the traditional birth culture in Canada: increasing industrialization led to a breakdown in the mutual aid networks that thrived mainly in farming environments; women's confidence in their ability to give birth and to help one another in childbirth seems to have gradually diminished; modesty came to be seen as increasingly important, and there grew a sense that decent people did not have babies in their homes; and, after the First World War especially, a taste for being innovative, progressive and modern became widespread, and home births attended by neighbour women were portrayed as inferior to modern, medically-managed childbirth.[12]

Perhaps most important, though, was the gradual establishment of the medical profession. From the 1850s onward, physicians made a strong and continuous effort to forge themselves into a unified profession, and to include midwifery in their practices. Obstetrical care, as practiced by the medical profession, seems to have made little accommodation of the popular birth culture; one of the guiding principles of obstetrics was that childbirth in the customary manner was potentially dangerous. Even so, the progression from the popular birth culture to modern obstetrics took place during a time when, for more than three decades, medically-managed birth in hospital appears to have been statistically more dangerous than birth carried out at home in the

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[12]Ontario Task Force on Implementation of Midwifery, p. 206.

traditional manner.[13] In its report, the Task Force on the Implementation of Midwifery in Ontario argued that midwifery did not yield to modern obstetrics because the latter was safer; rather, the campaign for modern (medical) childbirth was based primarily on the beliefs of its proponents.[14]

Technically, physicians had a monopoly over the practice of medicine, midwifery included, from 1865 on. Evidently though, the law made little impression on people in many areas as women continued to help their neighbours with childbirth. In some instances, physicians' associations took measures to stop midwives from practising. Initially, they would write a threatening letter to any midwife who had been reported by a doctor; rarely, they would charge and prosecute her. However, when a midwife was taken to court and it became apparent that she was not damaging her clients, prosecution seemed only to gain public sympathy for the midwife. Physicians also published articles in magazines and made public statements on the dangers of childbirth without medical supervision.

These efforts to promote the view that childbirth should be handled by someone with special training contributed to the onset in 1897 of a movement that could have strengthened the traditional birth culture - the formation of the Victorian Order of Home Helpers by the National Council of Women (NCW).

This movement arose as the result of efforts by a number of influential women who believed there was a need for trained childbirth help for pioneer women in outlying districts of the country. They envisioned this helper as "a practical woman who has some training and (who) will go from house to house doing all sorts of mercy and kindness, rather than (a trained) nurse just selected to go to a certain place to attend a certain case."[15] In part, the NCW wished to institutionalize lay midwifery and to improve upon it by giving women training, primarily in midwifery but also in first aid, simple nursing, and household economy and sanitation. Rather than sending strangers into communities, they wanted to use women who were established in their communities as the basic building blocks of the new system - "women who already live in these country

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[13]Childbirth mortality data have always played an important part in the midwifery debate. However, one must bear in mind that these data have a history of being somewhat inaccurate.

[14]Ontario Task Force on Implementation of Midwifery, p. 198.

[15]Public Archives of Canada, "The Victorian Order of Nurses, MG 27", I B5, Vol. 10, Memorandum to Montreal Local Council of Women, 1897.

districts, are respected, and have the confidence of their neighbours would be preferable to any others."[16]

Powerful opposition arose against the attempt by the NCW to upgrade existing "neighbour midwives" into salaried, official health workers. The opposition began in the ranks of trained nurses who were just starting to establish their own profession. They lobbied for trained nurses only to be accepted into the Order and for the name be changed from "Home Helpers" to "Nurses". The NCW eventually yielded and redefined the new Order. Instead of employing mature women already established in their communities, it would include trained nurses only; the name of the Order was subsequently changed to the Victorian Order of Nurses (VON).

Physicians had their own concerns about the VON, in particular, that its members should not be allowed to practise midwifery. The NCW relented again, and the charter of the VON was drafted to expressly forbid all except emergency midwifery.

The use of medical procedures during childbirth increased after the turn of the century, and this development led to nurses expanding their role in a different way. The gap between medically-managed birth and the traditional birth culture was widening, and educating women about childbirth became a major function of nurses. A great deal of their work over the first four decades of this century involved altering women's perceptions of birth, and emphasizing to them the importance of having one's pregnancy, and overall health, managed by a doctor. By the end of this period, the traditional birth culture had largely lost its popularity, and childbirth had moved from the community and family into a new environment created by expanding groups of professional medical workers.

Some historians have noted that the decline of midwifery in Canada should not be seen as simply a case of one discipline being superseded by another. As one writer stated,

> "It is sometimes asserted that it was the supposed illiteracy of midwives, as well as their political naivete, that led to their demise. But this supposes that midwives were in fact a group who could be corralled and led away. This notion gives an inaccurate view of the birth culture. ... midwifery was not a profession that was in any sense parallel to the (profession or) ambitions of doctors. To ask why midwives were not able to form themselves into an enduring profession in Canada, then, is to ask the wrong question. It is not that midwives - those many neighbour women who helped one another in childbirth - lacked the imagination or the

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[16]Public Archives of Canada, "The Victorian Order of Nurses MG 27".

> energy to build a profession that could challenge the doctors. It is that their imagination, and their culture, gave them a different vision ... (one in which) childbirth belonged to the community."[17]

In spite of the decline of the traditional birth culture, most commentators would agree that Canada has witnessed a significant resurgence of interest in midwifery over the past 20 - 30 years. According to advocates of midwifery, women became increasingly aware during the 1950s and '60s of the extent to which childbirth had come to be seen and treated not as a natural process, but as a medical event. They argue that women giving birth became disenchanted with what had become a highly technical, interventionist, physician-dominated hospital delivery system. In addition, social movements for women's rights and "medical consumerism" have contributed to an increasing public demand for greater control over health care services, including maternity care. Increasing numbers of childbearing women began to regard themselves as active users rather than passive recipients of maternity services, and sought more control and responsibility for the management of their pregnancies and deliveries.[18]

Reformers both inside and outside hospitals have set about trying to transform medical processes associated with childbirth so that it may be more satisfying for women, more involving for their partners and more gentle for their babies. Among these changes has been a renewed interest in midwifery and in alternative birth settings such as the home and birthing centres.[19]

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[17]Ontario Task Force on Implementation of Midwifery, p. 198.

[18]Manitoba Advisory Council on the Status of Women, Midwifery: A Discussion Paper (Winnipeg, May, 1987) p. 15.

[19]Alberta Health Occupations Board, p. 17.

V. LETTERS TO THE BOARD FROM INDIVIDUAL CITIZENS

Two hundred and forty-two citizens contributed letters of opinion to this investigation:

- 238 of the letters expressed support for legislative recognition of midwifery; most of these letters were also in favour of home births although two of the writers were specifically opposed to home births;
- three expressed support for legislative recognition of nurse-midwifery (as opposed to non-nurse midwifery); and
- one writer (a physician) opposed midwifery receiving legislative recognition.

The respondents who were opposed to home births and/or the designation of midwifery generally argued that there are greater inherent risks in home births and midwife-assisted deliveries than in hospital deliveries attended by a physician. This topic is dealt with in a later chapter on assessment of risk. This section provides a summary of the views of the large majority of respondents who expressed strong support for recognizing and regulating midwifery.

Several recurring themes appeared in the letters from respondents who wrote in support of midwives and home births. The most prevalent theme was that childbirth is a normal, healthy process in a woman's life that generally proceeds without complications and seldom needs to be subjected to medical interventions. Therefore, childbearing women should be given every opportunity to make their own informed choices about where, how and among whom they give birth.

Along with this theme, two related sentiments were evident in many letters. In the words of one respondent,

> "Childbirth is an event which can transform a woman's perception of herself and her relationships with others. From a fearful mother-to-be I became strong enough to deliver my baby and care for her with little support ... from the health care system; and
>
> "(all expectant parents are) looking for a normal, safe experience of childbirth which will provide an emotionally satisfying transition into parenthood."

With these thoughts in mind, why would virtually all the letter-writers prefer to be attended in childbirth by midwives, and most of them choose to deliver at home instead of in a hospital?

To begin, some women simply would rather give birth in the comfort and familiarity of their own homes instead of in hospitals. Home births were described as "peaceful", "intimate", "relaxed", "warm", and "quiet" in contrast to the "stark", "impersonal", "technological" and "confusing" environs of hospitals. In most cases this preference was a consequence of the different treatment received in these two settings. As one woman wrote,

> "A home birth compared to a hospital birth is as different as night and day. At my home birth, I was allowed to birth naturally with no interventions, the midwives were sensitive to my feelings, supported me through my entire labour, and (maintained) regard for my human dignity. At the hospital birth, many of the staff were insensitive, in some cases incompetent, and eager to use medical interventions that were unnecessary."

Another respondent was more explicit about her dissatisfaction with hospital births. She wrote

> "... I disliked the hospital scene. I hated to leave home when I went into labour. I hated (the) anaesthetic ... I hated the routine slicing and stitching. I hated getting shaved. I disliked giving up my baby to the nurseries."

Nearly everyone commented on the standards and thoroughness of prenatal care provided by midwives. For example,

> "The midwife's prenatal care was exceptional in quality. Her prenatal classes were superior in every way to those of the Edmonton Board of Health because the information was more specific and technical, and the atmosphere was more informal and supportive.
>
> At regular appointments, she administered the same physical check-up and measurements as the obstetrician, but unlike the doctor, she had time to talk about the emotional aspects of pregnancy, nutrition, (fitness) and family preparations for the new baby.
>
> By contrast, the doctor's office was crowded, appointments were overbooked, the waiting was interminable and the discussions were inevitably brief. The entire focus was on my medical condition, and the physical well-being of the baby, with little or no attention paid to my family's other needs.
>
> In pre-natal care, I could expect two hours of waiting for a five to 10-minute appointment with the doctor. At the midwife's office, there was no waiting for a 20-minute to 30-minute appointment."

Again, virtually all the respondents remarked on the care they received during labour and delivery. In particular, they criticized the medical interventions they were subjected to, and the lack of a sense of control when in hospital. An account of the pros and cons of these interventions is beyond the scope of this summary, but several points raised in the letters are appropriate to mention:

- an RN wrote that

> "all of the interventions associated with childbirth carry some degree of risk which may or may not be fully understood by either the doctor or the mother ... Repeated studies have shown that there is, in fact, a <u>better</u> outcome (in comparative rates of prematurity, morbidity and mortality) when intervention is minimized";

- another RN who has had midwifery training in England wrote that

> "... in my opinion, too often the care given by our medical colleagues to women in normal labour has been fraught with danger. I have seen far too many incidents (in which) the attending physician intervened in what was perhaps a slow but nevertheless normal delivery. I have agonized over the fact that the intervention was done to suit the doctor and not the patient ....";[20]

- and two other respondents added that

> "... routine augmentations, inductions, (cesarean sections) and episiotomies ... constitute an extreme violation to (some women) if they are not necessary"; and
>
> (these) interventions, ... if not endangering the baby, at least seriously discomfort the mother."

Several respondents wrote of how medical interventions undermine a woman's sense of control during delivery. One such intervention

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[20]Unnecessary interventions were variously attributed to constraints on physicians' time, physicians' fear of legal liability should problems occur in the absence of medical intervention and testing and the fact that a physician gets paid more for performing certain "additional procedures" during the course of a delivery.

was the administration of anaesthetics and other drugs. One writer stated that without drugs

> "the mother is better able to work with her body's normal birth process, thus avoiding much of the necessity for risky forceps and C-section delivery; neither mother nor baby is in danger of drug side effects, adverse reactions, or errors of administration; and both are more alert and responsive at birth, facilitating the very important process of bonding."

Many respondents also had a higher regard for the post-natal services provided by midwives than those provided by other health care personnel. One woman wrote

> "I never saw the doctor again after leaving the hospital except for a cursory post-natal check-up. My midwife visited our home frequently in the days after the birth and counselled the family in the early months about all aspects of baby care, breast-feeding, nutrition, even emerging sibling rivalry. In contrast, the public health nurse visited once for 10 minutes of pleasantries."

One of the most important reasons for why respondents preferred midwives is the continuity of care midwives provide. One woman wrote

> "The most important thing my midwife did was to be with me for the <u>whole</u> labour, delivery and immediate recovery."

Another wrote that

> "(with a) midwife .... a woman can be secure in the knowledge that the person she has planned on attending her birth will definitely be available and will stay with her throughout her labour. ... a large number of women do not have their (own) doctors attend the delivery due to on-call rotation schedules (and) it is very stressful for a woman to not know who will be assisting her with her delivery."

Several respondents raised concerns about the number of different health care personnel they encountered during conventional (physician-managed) care during pregnancy, labour, delivery and postpartum. For example,

> "Typically, an expectant woman has contact with a variety of health care workers during her pregnancy, including health unit nurses who teach prenatal classes, her family doctor or obstetrician who sees her on a monthly/weekly basis, hospital nurses on the labour and delivery floor,

> often an on-call doctor at the actual birth, a different team of nurses in the maternal/child unit of the hospital, and if she needs postpartum advice on breast-feeding, etc., she will likely turn to a private Nursing Mother's Group. How much more personal and effective to have continuity of care from a team of two or three midwives."

The benefits of midwives' continuity of care were said to go beyond mere familiarity between the childbearing woman and her midwife. As one woman stated,

> "Midwives are able to balance safety and support through the development of a trusting relationship throughout the pregnancy. The midwife at the birth is the same person who saw the woman throughout the pregnancy. Assessments made during labour are based on a thorough knowledge of the woman and her family. It is impossible for this depth of assessment to occur in the hospital setting where caregiving is fragmented. In the hospital, decisions may be made regarding the labour or even during the postpartum period that are based on a superficial assessment and therefore may have long term consequences for that woman and her family."

Many respondents wrote about the safety of midwife-assisted home births. Often they prefaced their comments with statements like

> "Do you honestly think that the parents who have home births are so uncaring and have so little regard for their unborn babies that they would willingly jeopardize their lives and the lives of their babies if the statistics proved that home births were so unsafe?"

Because a midwife-assisted home birth is not the conventional means of childbirth in Alberta, women who chose this route appear to have done extensive research to become convinced they were not exposing themselves or their unborn children to undue risks. One woman offered her conclusion that

> "A well trained midwife is equipped with skills to deal with emergency situations but even more importantly, with such a solid understanding and familiarity (with) the variations (from) a healthy pregnancy and delivery, the midwife is very quick to recognize when other medical support is required."

This idea is reinforced by remarks in other letters about midwives being "experts in normal childbirth", carefully screening their prospective clients for suitability, and encouraging transfers to hospital for childbearing women who require more extensive medical care than midwives can provide.

Two writers commented about back-up services and procedures for home births:

> "Medical attention (is) available for women in labour within mobile facilities that already exist today. Paramedics, the University of Alberta Medical Air Team, this city's firefighters and rescue and medical emergency units - all serve as examples of proven response systems. I can easily envision a similar service which supports exclusively the .... practice of midwifery"; and

> "the time involved in setting up for an emergency such as a cesarean section would certainly give most women time to be driven from home to a hospital. It is a very rare situation where there is absolutely no warning of the emergency and the hospital staff is prepared to actually intervene within minutes. When complications are suspected, preparations begin. This can and does happen in the home situation as well."

Lastly, two women provided interesting perspectives on the issue of safety of midwife-assisted home births. One asserted that

> "Both hospital births and midwife-assisted home births are safe. We have reached a point where the statistics should be put aside temporarily and where the anecdotal evidence should <u>especially</u> be considered. It is in the experiences of the women and families affected by the birth experience that the matter will be resolved";

and the other wrote

> "in an area as sensitive as childbirth, we need to ask ourselves if the end result is the only result by which we define success."

Perhaps the strongest statements in support of midwifery described attributes of the midwives themselves and the care they provide. In letter after letter midwives were praised for their perspectives on childbirth and the manner in which they perform their work.

Respondents wrote, for example, that midwives take a "wholistic, spiritual, family-based approach to birth", and "promote education, self-empowerment, (wholesome) nutrition, wellness and the normalcy of birth"; they stress the importance of "awareness, confidence and a positive (outlook)", and encourage women to "enjoy childbirth"; midwives "monitor (women in their care) for complications, but (do) not focus on possible problems." Some women remarked that they view midwives as mothers and wives, too, so they are better able to understand and empathize with childbearing women.

Letter writers expressed a high regard for midwives' knowledge and skill in all aspects of childbirth and also for their manner of care. One woman wrote

> "The midwives ensured (the) physical health and safety of myself and (my baby), and also cared for my emotional and spiritual needs."

Another stated that midwives treated her with "gentleness, calmness and such sensitivity." Throughout the letters midwives are described as "warm", "caring", "kind", "compassionate", "professional", "respectful", and "tender".

Interestingly, there was virtually no direct criticism of physicians in the letters. Indeed, several respondents remarked that they had great respect for physicians; however, they added that physicians' skills and sophisticated medical technology are necessary in only a small percentage of births. Some writers commented that they believe the training of physicians (and consequently, the care they provide) focuses primarily on difficulties and complications in childbirth. Therefore, they have opted for a midwife's more positive approach to care instead. Other writers stated that physicians simply did not have enough time to provide the support through pregnancy and labour they desired.

VI. OVERVIEW OF MAJOR ISSUES AND POINTS OF VIEW PRESENTED IN BRIEFS

Sixty-two (62) of the 107 organizations (58%) contacted for information returned either a completed questionnaire or some other form of written brief to the Board. Several of the responding organizations also submitted lengthy reference documents concerning midwifery along with their briefs.

Throughout the briefs there was little disagreement about what the actual practice of midwifery entails (or should entail). Many respondents simply referred to the World Health Organization's definition of a midwife (presented on page 7 of this report) for a description of a midwife's functions. There was also near-unanimous acceptance, if not outright support, that some form of midwifery could be recognized in Alberta and regulated through professional legislation, although not necessarily the Health Disciplines Act. Several organizations, however, imposed conditions on their acceptance of legalized midwifery in Alberta, and these conditions reflect four major points of contention.

First among these conditions is that midwives' services are shown to be needed in the province. As the Alberta Society of Obstetricians and Gynaecologists wrote in its brief,

> "in accordance with a Canadian Medical Association (CMA) guideline, ... another health care occupation (midwifery) should be established only when a need for that occupation has been demonstrated, and the possibility of using already established personnel to fulfil the need has been ruled out."

Furthermore, the CMA reportedly did

> "its own study of obstetrical care (and) concluded that the present system contains all the resources and personnel required to provide Canadian women with the highest quality of obstetrical care."[21]

In contrast, supporters of midwives feel that childbearing women must have the opportunity to make informed choices in childbirth from a range of alternatives that includes care from a midwife. They also view the addition of midwives to the maternity care team as an enhancement to the present health care system.[22]

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[21]Maureen Baker, Midwifery: A New Status, Research Branch, Library of Parliament (Ottawa, October, 1989) p. 24.

[22]Manitoba Advisory Council on the Status of Women, p. 42,50.

There is considerable disagreement about the actual legislation and governing body midwifery should be regulated under if it becomes regulated.[23] Both physicians' and nurses' associations have suggested that midwifery could be incorporated into the Nursing Profession Act and hence, be governed by the Alberta Association of Registered Nurses. However, midwives generally want to be governed under legislation that would allow them to become an autonomous, self-regulating profession responsible for developing their own standards of practice and for licensing and disciplining members.[24] The form of legislation, they believe, would affect the nature of the relationship between themselves and physicians (i.e., whether it would be collegial, consultative, or one of accountability to physicians).[25]

Closely tied to opposing views on legislation is the question of whether midwives should have prior training as nurses. Some of the responding organizations regard midwifery as an advanced specialty of nursing, and believe that midwifery should be practiced only by RNs who have appropriate advanced training. Other organizations feel that midwifery is a distinct profession apart from nursing and, therefore, that midwives should not be required to have a registered nursing qualification.

Finally, medical associations (and others) are opposed to midwives practising independently, especially as this may enable them to attend home births.

Canadian medical associations have adopted the position that childbearing women subject themselves and their babies to unnecessary risks when they choose to give birth at home. Moreover, these associations believe that midwives would not have adequate training, knowledge or equipment to deal with medical emergencies that could arise during childbirth in someone's home.[26] Most midwives, however, feel that assisting at home births is an integral part of midwifery, and contend that birth in the home is no more dangerous or risky than birth in a hospital (i.e., for women judged to have low-risk pregnancies). They wish to continue to attend home births with the cooperation and support of physicians and hospitals for emergency situations. However, Canadian medical associations have advised their members not to cooperate with midwives who are assisting at planned home births.[27]

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[23]Maureen Baker, p. 24.

[24]Manitoba Advisory Council on the Status of Women, p. 33.

[25]Manitoba Advisory Council on the Status of Women, p. 33.

[26]Maureen Baker, p. 2.

[27]Maureen Baker, p. 2.

The rest of this report deals more thoroughly with these points of contention as well as other issues that have arisen in the course of this investigation.

VII. REGULATION

A. Status of Midwifery in Alberta

Provisions in two legislative Acts have a bearing on the practice of midwifery in Alberta. Firstly, in the Medical Profession Act, "medicine" is defined to include obstetrics, and the Act restricts the practice of medicine to physicians who are registered with the College of Physicians and Surgeons. There are, however, two exceptions in this Act relevant to midwifery:

- section 23(2) states that "persons registered in (a) Special Register are entitled to practise medicine, surgery and midwifery" under specified conditions, and

- section 76(5) states that non-registered medical practitioners are not guilty of an offence if they practise midwifery outside of "territories ... within the limits of a city, town or village having a resident registered practitioner in midwifery therein."[28]

The other item of legislation that pertains to midwifery is section 2 of the Nursing Profession Act which states that

> "(a) registered nurse and a certified graduate nurse are entitled to apply nursing knowledge for the purpose of ... assisting in childbirth ..."[29]

No other particulars or conditions about the role of nurses during childbirth are in this Act.

The Medical Profession Act, apart from the exemption in section 76(5), seems to prohibit anyone except a duly registered medical practitioner from practising midwifery.[30] This prohibition, however, is in the process of being challenged.

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[28]"Medical Profession Act", Revised Statutes of Alberta, Vol. 8 (Edmonton, 1985), p. 28.

[29]"Nursing Profession Act", Revised Statutes of Alberta, Vol. 10 (Edmonton, 1983), p. 5.

[30]In spite of this prohibition, approximately 1000 births have been managed by midwives in Edmonton and the surrounding area in the last ten years alone. More information on the recent activities of midwives in Alberta is presented in the chapter on assessment of risk.

In August of this year, the Alberta Attorney General, acting on a complaint lodged by the College of Physicians and Surgeons, charged an Edmonton-based midwife with practising medicine without a license. In response, legal counsel for the midwife filed a Notice of Constitutional Question in the Provincial Court of Alberta. The Notice states that "the accused ... wishes to challenge the constitutional validity of (subsections) 76 and 77 of the Medical Profession Act", primarily because they limit the life, liberty and security of midwives and women who wish to retain the services of midwives.[31] Arguments in support of this Notice were presented to the Court on October 12, but the Court rejected the application to consider the constitutional arguments separate from the trial.

The trial is scheduled to take place in the spring of 1991. Counsel for the midwife concerned is expected to argue before the Court that his client is not guilty of the charge because midwifery is not part of the practice of medicine.

B. Status of Midwifery in Other Canadian Provinces and Territories

All provincial and territorial governments except those for Nova Scotia and the Yukon provided a statement or other information on the status of midwifery in their respective jurisdictions. Most of these governments have no statutory provision for midwifery apart from the obstetrical services provided by medical doctors:

- New Brunswick "does not have any legislation regarding midwifery nor does it contemplate establishing legislation in the near future";[32]

- Prince Edward Island "has no midwives practising and ... no legislation or regulations with regard to midwifery. (The Province) did look at the possibility of midwives providing services on PEI ... but felt ... the provision of these services was still a few years away";[33]

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[31]Notice of Constitutional Question filed in the Provincial Court of Alberta, Judicial District of Red Deer, 27 September, 1990.

[32]Letter from Mr. Jean-Guy Finn, Deputy Minister of New Brunswick Health and Community Services to the Health Disciplines Board, 2 May, 1990.

[33]Letter from Ms. Jeanette MacAulay, Director, PEI Hospital and Health Services Commission to the Health Disciplines Board, 27 April, 1990.

- In Saskatchewan and British Columbia "midwifery is currently considered (part of) the practice of medicine within the terms of the Medical Profession (Practitioners) Act, ... (but) the regulation of midwifery is presently under review".[34] In BC, the Government is presently considering the regulation of midwifery under its newly enacted Health Professions Act. In addition, it recently asked the Interdisciplinary Midwifery Task Force of BC to carry out a study of the acceptability of midwifery in that province;[35]

- In the Northwest Territories (NWT), "there are no provisions in (its Medical Professions) Act allowing for the licensing of midwives ... the Act only affects midwives by making it illegal to practice midwifery if (it) falls within "practising medicine"; (however,) there are no cases issued from NWT courts on this point";[36]

- Newfoundland does have a Midwifery Act that "has been in effect since the early 1950s (but) has not been active for quite a while. ... it is somewhat archaic and is no longer considered to have any practical application. ... The Midwifery Act ... does not provide any protection or restrictions with respect to the practice of midwifery today."[37]

Despite the absence of legislation (or at least current legislation) in these provinces, midwives continue to practise and promote the idea of legalizing midwifery. For example, 300 to 400 midwife-attended births are occurring in BC each year, and interest in legalizing midwifery appears to be growing.[38] In northern Newfoundland and Labrador, there are specially trained nurses who practice midwifery in cooperation with, or under the supervision of, physicians; however, the movement for independent midwifery seems to be getting stronger.[39] And in the NWT, the government

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[34]Letter from Mr. J.C. Lovelace, A/Deputy Minister, BC Ministry of Health to the Health Disciplines Board, 25 May, 1990.

[35]Maureen Baker, p. 16.

[36]Letter from the Government of the NWT to the Health Disciplines Board, 18 April, 1990.

[37]Letter from Ms. Kathy Babstock, Program Coordinator, Newfoundland and Labrador Department of Health to the Health Disciplines Board, 17 May, 1990.

[38]Maureen Baker, p. 14,16.

[39]Maureen Baker, p. 23.

policy of transporting pregnant women to regional health centres for childbirth has led to "dissatisfaction of families and communities, (and) resulted in an interest and call to revitalize midwifery services." The NWT Department of Health has responded by recommending the "implementation of two pilot projects on midwifery, (and that) consideration be given to the development of legislation concerning midwifery."[40]

The provinces of Quebec and Ontario have taken more definite steps toward incorporating midwives into their respective health care systems.

In Quebec, a Commission of Inquiry into Health and Social Services prepared a report on midwifery in 1988, and recommended that it be granted legal recognition. In addition, a Provincial Task Force on Midwifery also recommended that midwives be regulated, and an Advisory Council on Social Affairs urged the government to set up a three-year pilot project in which midwives would manage selected low-risk births. In March, 1989 the Minister of Health and Social Services announced her intention to allow midwives to practise in some hospitals on an experimental basis in spite of opposition from Quebec's medical associations.[41]

In June, 1990 the Government of Quebec assented to a Bill which allows midwifery to be practised in eight pilot projects affiliated with Quebec's health care system.[42] As stated in the Bill, these pilot projects are

> "principally aimed at evaluating the effects of midwifery practice on the humanization and continuity of care, the prevention of premature births and low birth weight, the use of obstetrical technology and the adaptation of services to intended clients, with a view to determining whether it is advisable to allow the practice of midwifery and, if expedient, determining the professional organization of midwifery practice and the mode of integration of the midwife in the perinatal care staff."[43]

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[40]Letter from Ms. Maureen Morewood, Assistant Director, NWT Health to the Health Disciplines Board, 8 June, 1990.

[41]Maureen Baker, p. 21.

[42]Bill 4, "An Act respecting the practice of midwifery within the framework of pilot projects", National Assembly of Quebec, 1st session, 34th Legislature, assented to 22 June, 1990.

[43]Bill 4, "An Act respecting the practice of midwifery within the framework of pilot projects", p. 5.

For the purposes of these projects, midwives will be allowed to carry out all of their normal duties, as well as to perform vaginal exams using a speculum, amniotomies, episiotomies, and repairs of episiotomies and minor lacerations of the perineum. They will be able to practise independently (i.e., without a physician's direct supervision), and patients will be allowed to consult with midwives directly (i.e., without a referral from a physician).[44]

Midwives, however, did have two restrictions placed on them:

- they will attend births only in a hospital or in a facility affiliated with a hospital (i.e., no home births); and

- a woman may use the services of a midwife only if her pregnancy is determined to be "low risk".[45]

Furthermore, the practice of midwifery will only be lawful within the guidelines of the pilot projects for the next six years.[46]

In Ontario, midwifery appears to be on the verge of becoming a regulated discipline in the province's health care system. Even so, midwives practising now are "primarily outside the official health care system."[47]

The events that led to the present situation began with the death of a baby at a midwife-attended birth in Toronto in 1985. A coroner's inquest was held and the jury recommended, in part, that midwifery be regulated by law in Ontario.[48]

At the same time, Ontario's Health Professions Legislation Review (HPLR, created by the Minister of Health in 1982) was studying the question of which health professions should be regulated. In 1986, on the recommendation of the HPLR, the Minister of Health announced the government's intention "to establish midwifery as a recognized part of Ontario's health care system" and that it would become a

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[44]Office des Professions du Quebec, Midwifery Brief Submitted to the Health Disciplines Board.

[45]Criteria for determining which pregnancies are low-risk were not provided.

[46]Office des Professions du Quebec, Midwifery Brief Submitted to the Health Disciplines Board.

[47]Letter from Ms. Mary Catherine Lindberg, Assistant Deputy Minister, Ontario Ministry of Health to the Health Disciplines Board, 1 June, 1990.

[48]Maureen Baker, p. 18.

regulated health profession. A Task Force on the Implementation of Midwifery in Ontario was established to make recommendations on scope of practice, governance, education and entry-to-practice qualifications.[49]

The Task Force submitted its report in 1987, and recommended that midwives be licensed as independent professionals, that they not require a nursing certificate as a pre-requisite to training or practice, and that they be trained in a four-year university program. The Task Force also recommended the establishment of a College of Midwifery to regulate the profession and a series of safeguards to ensure the highest standards of practice.[50]

Legislation based on the HPLR and Task Force recommendations was introduced in the Ontario legislature during the Spring, 1990 session. The proposed Midwifery Act outlines a scope of practice, a regulatory structure and its regulation-making powers. The scope of practice for midwives is consistent with the recommendations made by the Task Force.[51]

An Interim Regulatory Council on Midwifery (IRC) was appointed by the government in May, 1989 to advise the Minister of Health on matters such as the development of standards of practice and criteria for registration. The IRC will function until the Midwifery Act is proclaimed and a statutory College of Midwives is established.[52]

C. Regulation of Midwifery in Selected Countries

Although the situation appears to be changing, Canada is presently the only developed nation among the 210 countries in the World Health Organization that does not recognize and regulate the practice of midwifery within its health care system. Eight other countries make no provision for midwifery: Venezuela, Panama, New Hebrides, El Salvador, the Dominican Republic, Honduras, Columbia, and Burundi.[53]

There are various forms, or models, of regulation of midwifery in countries throughout the world (although some of these models are

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[49]Letter from Ms. Lindberg, Ontario Ministry of Health.

[50]Maureen Baker, p. 19.

[51]Letter from Ms. Lindberg, Ontario Ministry of Health.

[52]Letter from Ms. Lindberg, Ontario Ministry of Health.

[53]College of Nurses of Ontario (CNO), "Midwifery - A CNO Policy Background Paper" (March, 1986), p. 50.

more relevant than others to the health care situation in Alberta). Regulations define how midwifery is practiced and the degree of independence, or autonomy, that midwives may exercise. Indeed, as is evident in Canada, relatively restrictive legislation concerning obstetrical care may even prompt midwives to work outside a country's official health care system and the law.

Many organizations submitted information to this investigation on how midwifery is regulated and practiced in other countries. Brief accounts of regulation and some features of midwifery practice in three countries are presented below for reference. Some remarks are made about midwives' independence of practice; however, the degree of independence is inextricably bound to a midwife's scope and setting of practice, so further remarks on independence will be made in a later chapter that deals with scope of practice.

1. The United States

The most striking feature of midwifery in the United States is that it is practised by two entirely separate groups of midwives: those who first qualified as nurses and then completed a recognized nurse-midwifery training program leading to the designation certified nurse-midwife (CNM), and those who were prepared through a variety of other routes and are known variously as "non-nurse midwives", "lay midwives", "granny midwives", "empirical midwives" or "direct entry midwives". CNMs are very similar in educational background, philosophy, and standards of practice; non-nurse midwives are exceptionally diverse and include practitioners who have received formal education from direct entry schools of midwifery as well as apprentice-trained and self-taught practitioners. While CNMs constitute a clearly identifiable profession, non-nurse midwives are in some respects more a movement than a profession.[54]

CNMs are regulated by both their professional organization, the American College of Nurse-Midwives (ACNM), and by state licensing boards. The ACNM maintains certain standards of practice, an important one being that CNMs are required to have collaboration agreements with physicians for back-up and consultation.

Legal authority to practice is granted or withheld by each state. As of January, 1986 North Dakota was the only American state in which statutory authority for the practice of nurse-midwifery was unclear; in every other state some provision has been made for the legal regulation of nurse-midwifery although there are a variety of governing authorities. In 34 states nurse-midwives are regulated by boards of nursing. In many of these states nurse-midwives are

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[54]Ontario Task Force on Implementation of Midwifery, p. 329.

defined as advanced registered nurse practitioners.[55] In five states they are regulated jointly by boards of nursing and medicine; in four states they are regulated by boards of medicine alone; in six states they are regulated by departments of public health; in one state they are regulated by a committee of CNMs within the department of business regulation; and another state has a "mixed statutory authority" with more than one midwifery related statute.[56]

A link between professional self-regulation and legal regulation is made in the 43 states which recognize ACNM certification and/or graduation from an ACNM accredited educational program as the basic requirement for practising nurse-midwifery.[57] Seven states require continuing education units to be taken for renewal of authorization to practice.[58]

There appears to be variation in the degree of autonomy permitted by each state. For example, in Ohio, the Medical Practice Act states that midwives "at all times shall practice midwifery under the direction and supervision of a doctor of medicine or doctor of osteopathic medicine and surgery holding a license to practice medicine or surgery". In contrast, other states allow nurse-midwives to be in private practice as long as they have written evidence of a collaboration agreement with a physician.[59]

Interestingly, CNMs have found it difficult to carve out a niche in the health care market, between obstetricians on the one hand and non-nurse midwives on the other. For much of their history, nurse-midwives' goal was to achieve recognition by differentiating themselves from non-nurse midwives. In the 1970s and '80s they were criticized for reaching their goal too well; literature of the alternative birthplace and home birth movements faulted them for having been co-opted by doctors and for offering no real alternative to the medical model of childbirth.[60]

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[55]College of Nurses of Ontario, p. 62.

[56]College of Nurses of Ontario, p. 62.

[57]Four states require that this education be to a baccalaureate or Master's degree (from Ontario Task Force on Implementation of Midwifery, p. 42).

[58]College of Nurses of Ontario, p.

[59]In come cases, nurse-midwives in private practice have had difficulty getting these collaboration agreements because they are viewed by physicians as competitors (from the Ontario Task Force on Implementation of Midwifery, p. 43).

[60]Ontario Task Force on Implementation of Midwifery, p. 43.

Non-nurse midwives have been less successful than their counterparts at gaining legislative recognition. Non-nurse midwifery is:[61]

- clearly prohibited through statutory restriction or judicial interpretation in nine states;
- in five states, prohibited unless a practitioner was licensed before a certain date;
- not legally defined (i.e. not specifically prohibited) in 14 states; and
- in eight states, legal by statute although licensure is unavailable, unattainable, nonexistent, or very restrictive.

Non-nurse midwifery is clearly legal with active licensing or registration processes in eight states, and is legal through judicial interpretation or statutory inference in another six states.

In states where non-nurse midwives are legally recognized and regulated by statute, they are subject to different, more restrictive regulations than CNMs. Nowhere in the USA do non-nurse midwives have hospital privileges or coverage by Medicaid or private health insurance. They are not employed by hospitals, but some do work in free-standing childbirth centres.[62]

In several states, organizations of non-nurse midwives are pressing for legal recognition or better treatment under the law. However, these organizations have sometimes shown a rather ambivalent attitude about gaining legislation and becoming integrated into the official health care system. Some of them feel this leads inevitably to too much adherence to a medical approach to childbirth and loss of the distinctive alternative they offer. For example, they point out that CMNs working in institutional settings must follow policies and protocols and are not free to choose their clients. Non-nurse midwives who work on their own or in independent groups can control every aspect of their practices.[63]

Non-nurse midwives are closely associated with the home birth movement, and this helps explain why physicians are generally opposed to them, whether they are licensed or not. Physicians are also concerned about their legal liability if they provide medical backup for cases managed by non-nurse midwives, and they sometimes

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[61]Source unknown

[62]Ontario Task Force on Implementation of Midwifery, p. 44.

[63]Ontario Task Force on Implementation of Midwifery, p. 45,46.

fear they will lose their own insurance coverage if they support uninsured midwives.[64]

2. The Netherlands[65]

In the Netherlands, the prevailing view is that pregnancy and childbirth are normal physiological processes that rarely require medical intervention.

Midwives have been licensed by the government since 1865. Midwifery is not allied to nursing; instead, it is treated as a medical profession, and is regulated (in matters of discipline) by the same college that regulates physicians. Interestingly, midwives in the Netherlands swear the Hippocratic oath.

Seventy percent of the approximately 1000 licensed midwives in the Netherlands work in private practice, often in groups of two or three; the others are salaried employees in hospitals or clinics. In keeping with the high proportion of midwives in private practice, 34% to 36% of all births annually take place in women's homes. However, midwives in private practice all have contracts with hospitals which allow them to admit women. All midwives appear to be practising within the Netherlands' official health care system.

Midwives have a great deal of autonomy and exercise a high level of responsibility. They are recognized as experts in the management of normal pregnancy and delivery. Midwives may make the diagnosis of pregnancy, and determine the classification of a pregnancy: either "physiological", and therefore suitable for a midwife to handle, or "pathological", those which must be referred to an obstetrician. There is a third classification for patients who have to deliver in hospital but, unless problems actually develop, may be attended by midwives or general practitioners. Pregnancies are classified as physiological or pathological according to a well-established list of criteria.

Government policies and programs are geared to support midwifery in the Netherlands. For example, midwifery schools are nationally supported and regulated to ensure that graduates are highly competent at managing healthy pregnancies and identifying cases at risk. In addition, the national health insurance system discourages women from choosing to be cared for by a general practitioner or obstetrician instead of a midwife unless there is a medical need, and encourages them to deliver at home. There is also an ambulance system and cooperative arrangements with

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[64]Ontario Task Force on Implementation of Midwifery, p. 46.

[65]Ontario Task Force on Implementation of Midwifery, pp. 46-50.

obstetricians and other hospital staff that midwives can rely on should problems arise during childbirth or recovery.

3. The United Kingdom[66]

The legislation that currently regulates midwifery in the United Kingdom (UK) is the Nurse, Midwives and Health Visitors Act passed in 1979. This Act established a Central Council (UKCC) for nursing, midwifery and health visiting (similar to public nursing), and National Boards for the four countries of the UK (England, Wales, Scotland and Northern Ireland).[67]

Section 2.1 of this Act states that

> "(the) principle functions of the Central Council (are) to establish and improve standards of training and professional conduct for nurses, midwives and health visitors."[68]

As such, the UKCC has published "Midwives Training and Practice Rules" as well as codes of practice and professional conduct for midwives. The Central Council also maintains a register of these practitioners.

"Midwives Codes of Practice" describes the responsibilities of midwives and doctors as "inter-related and complementary ... however, (practitioners) retain the clinical accountability for their own practice."[69] Midwives must call a doctor in emergency situations or whenever they discover in the mother or baby a "deviation from the norm."

The National Boards are primarily responsible for training practitioners to UKCC standards. Each National Board (as well as the Central Council) has a Midwifery Committee which must be consulted on all matters related to midwifery. Midwifery services are arranged by geographic region, and each regional health authority has a midwifery supervisor who is responsible for all

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[66]Ontario Task Force on Implementation of Midwifery, pp. 58-61 (unless otherwise noted).

[67]United Kingdom Central Council for Nursing, Midwifery and Health Visiting, Midwifery Brief Submitted to the Health Disciplines Board, p. 3.

[68]United Kingdom Central Council, p. 3.

[69]United Kingdom Central Council, Code of Practice for Midwives, p. 4.

hospital and community midwives in the region maintaining professional practice standards.

Nearly all of the UK's 30,000 practicing midwives are employees of the National Health Service (NHS); the remaining few practice independently in the private sector. The majority of midwives employed by the NHS work in hospitals where they staff all parts of maternity services, including nurseries and neonatal special care units. The minority are in community-based centres, and make post-partum home visits, teach parentcraft classes and, to a limited extent, provide pregnancy care in general practitioners' offices.

The organization of midwifery services has tended to force midwives to specialize in one or two areas of care, and has sharply divided the responsibilities of hospital and community midwives (for example, community midwives have little involvement with labour and birth). A consequence has been that continuity of care from individual midwives has largely been lost. Moreover, the sharing of responsibilities between midwives and physicians has tended to diminish the midwife's overall role in assessing and caring for women during pregnancy. In many hospitals, physicians or unit policy now dictates the management of normal pregnancy, instead of a midwife. In contrast, midwives who practice privately provide complete prenatal, childbirth (in home or hospital) and postpartum care.

Restrictions on the midwife's role appear to have contributed to a high rate of attrition from the profession and an acknowledged shortage of midwives. In addition, it seems many British midwives are unhappy with the present form of governance. They feel that regulating midwives together with health visitors and a very much larger group of nurses undermines the status and identity of midwifery as a profession separate from nursing.

Today, only about one percent of births take place in women's homes, and only two-thirds of these are planned. However, in a survey, midwives reported that they would attend more home births except for the reluctance of physicians to provide back-up services, and local policies against childbirth in homes.

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Although midwifery regulation and practice varies in different countries, most Western nations have been experiencing common trends in reproductive care that have had an influence on the regulation of midwives. Primary among these trends are that:[70]

- more and more, childbearing women have been visiting their care-givers (instead of vice-versa), and the site of visits

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[70]Ontario Task Force on Implementation of Midwifery, p. 62.

has increasingly become a hospital or clinic instead of a home or neighbourhood meeting place;

- the ability to identify women with abnormal pregnancies has been superseded by the ability to identify women at risk of having an abnormal pregnancy. There has also been a tendency toward defining more and more risk factors, and focusing on physiological conditions related to risk rather than social and psychological conditions; care has been affected accordingly. (The technology used to screen for risk factors has also strengthened the move toward hospital-based childbirth);

- there has been a growing expectation that care-givers intervene in pregnancy or during birth when abnormalities are detected or even suspected. Increasingly, these interventions are being done according to medical protocols, and using medical instruments and technology; and

- pregnancy, birth and postpartum are now often regarded as three clinical situations which require different personnel and expertise; thus, continuity of care has been disrupted.

Collectively, these trends have decreased the midwife's role in reproductive care and, correspondingly, expanded the role played by physicians.[71] In general, these changes have been reflected in more restrictive regulations being gradually imposed upon midwives' practices. In some ways midwives have been transformed into physicians' assistants.[72]

Despite the apparent restrictions, however, the Ontario Task Force on the Implementation of Midwifery found that

> ". . . midwifery care is most effective when midwives can practice autonomously through their full scope of practice and when midwifery is recognized as an independent profession. ... Midwives must be permitted to take responsibility for the management of their clients' care; they should not be used as extended role nurses or physicians' assistants."[73]

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[71]Ontario Task Force on Implementation of Midwifery, p. 62.

[72]Ontario Task Force on Implementation of Midwifery, p. 62.

[73]Ontario Task Force on Implementation of Midwifery, p. 12.

Moreover, the Task Force asserted that

> "midwives must be fully integrated into the overall health care system if they are to provide safe and effective care. ... Midwives and physicians must cooperate with each other ... and collectively agree on such things as protocols for referrals and consultations." [74]

The Alberta Association or Midwives (AAM) believes that midwives can achieve a measure of the autonomy and self-governance they seek by being designated and regulated under the Health Disciplines Act. Ideally, they and their supporters want independent legislation for midwifery, and a distinct role in the health care system for midwives similar to that of physicians and registered nurses. The AAM would like midwives to be regarded as experts in normal, low-risk childbirth; they would also like to establish a cooperative, collegial relationship with physicians rather than function as their assistants. Midwives generally contend that if they have to work under the authority of physicians (or nurses), their philosophy and handling of childbirth as a normal, healthy function of women may be undermined.[75]

The College of Physicians and Surgeons of Alberta and the Alberta Association of Registered Nurses (among others) oppose the designation of midwifery under the Health Disciplines Act. These organizations feel that regulation of midwives would be more appropriate through the Nursing Profession Act, if regulation is deemed necessary at all. They believe that, if allowed to practice, midwives should be hospital employees accountable to appropriate authorities in obstetrics and nursing (i.e., midwives should not be allowed to practice independently). Furthermore, they disapprove of establishing a distinct profession of midwifery arguing that this would further fragment Alberta's health care system.

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[74]Ontario Task Force on Implementation of Midwifery, p. 12.

[75]Maureen Baker, p. 24.

VIII. TRAINING OF PRACTITIONERS

A. Training Programs in Alberta

At present, there are no training programs specifically for midwives in Alberta. However, since 1986, the University of Alberta Faculty of Nursing has offered students enroled in its Master of Nursing program the opportunity to attain a "Certificate in Nurse-Midwifery."[76]

The requirements for this certificate are, in addition to the normal Master of Nursing degree requirements, courses in: nursing care of normal and high risk newborns; health care of women in their reproductive years; care of the family during labour, delivery and the postpartum period; social and cultural contexts of reproductive care; reproductive physiology; and a midwifery practicum.[77]

Six students have graduated from this certificate program and two students are currently enroled.

B. Training Programs in Canada

At present, there is only one other institution in Canada that offers training in midwifery - the British Columbia School of Midwifery. This institution is not recognized or funded by the Government of BC. However, it is included in a list of direct entry training programs for midwives compiled and published by the Midwives Alliance of North America (MANA). The BC School of Midwifery made a submission to the Board as part of this investigation, and included a description of its training program. In short, the curriculum is divided into academic and clinical sections. The academic section lasts 12 months and includes 573 hours of didactic instruction, 172 hours of "clinical preceptorships" and an unspecified number of hours spent observing births. Students must then apprentice for at least 15 months with a qualified midwife.[78,79]

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[76]Manitoba Advisory Council on the Status of Women, p. 34.

[77]University of Alberta, Calendar for 1990-91 (Edmonton), pp. M7-M9.

[78]British Columbia School of Midwifery, Midwifery Brief Submitted to the Health Disciplines Board.

[79]Manitoba Advisory Council on the Status of Women, p. 34.

The Government of Ontario, in keeping with its intention to legalize and regulate midwifery, has been working toward establishing a midwifery training program in the province. According to the recommendations of the Task Force on the Implementation of Midwifery in Ontario, this program will have multiple routes of entry (i.e., direct and by way of nursing), be based at a university and consist of two integrated streams. These streams will be a four-year program leading to a baccalaureate degree in midwifery and, for people who have university-level training in nursing, a 12-18 month program leading to a diploma in midwifery.[80] A project to define the essential elements of a curriculum for this program is now under way.[81]

C. An Overview of Training Programs in Other Countries

As with the two forms of midwifery that are regulated in the United States (i.e., nurse-midwifery and non-nurse midwifery), there are also two types of training programs.

The ACNM, through its Division of Accreditation, monitors and evaluates the quality of nurse-midwifery education programs in the USA. At present, there are 29 of these training programs accredited by the College.[82] The ACNM certifies graduates of the educational programs it accredits and who pass the national certification exam it administers.[83]

There are also direct entry training programs for midwives available in the USA. MANA[84] published a list in March, 1990 of 31 programs that offer such training, but notes that "currently (in North America) there is no mechanism for national accreditation of

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[80]Ontario Task Force on Implementation of Midwifery, p. 20.

[81]Ontario Ministry of Health, Midwifery Brief Submitted to the Health Disciplines Board, p. 8.

[82]ACNM, Appendix to its Brief to the Health Disciplines Board entitled,"Educational Programs Accredited by the ACNM Division of Accreditation", (July, 1990).

[83]College of Nurses of Ontario, p. 67.

[84]The Midwives Alliance of North America (MANA) is a professional association of midwives not restricted to those who have a nursing credential (as is the ACNM). Even so, the Ontario Nurses Association reported in 1986 that approximately half of MANA members were CNMs.

direct entry midwifery programs (although) some are recognized by the state in which they are located."[85]

In Europe, some countries require that prospective midwives first study nursing whereas others do not. For example, in Scotland, Finland, Sweden and Norway, only qualified nurses may take midwifery training. In Denmark and France, nursing is not a prerequisite for midwifery training. Midwifery training in Germany and Belgium is separate from nursing although some nursing education is included in midwifery programs.[86]

In England and Wales, there are both direct entry and post-nursing training programs for midwives. Direct entry training lasts three years, whereas training for those who are already registered general nurses lasts 18 months. Once midwives become qualified to practice, there is no distinction made between them on the basis of route of training.[87]

The Netherlands Midwifery Association reported in its brief that the training programs in that country also last three years, but they are likely to change to four-year programs in 1991. The Association also stated that since January, 1980 the midwifery training programs in all countries of the European Economic Community have had to meet certain requirements set by the EEC. These requirements were provided by the UKCC and are included here as an example of a widely-accepted outline of education and training for midwives (see Table 1: "Training Program for Midwives in Countries of the European Community"). In short, the program of the European Community is made up of science courses relevant to pregnancy and childbirth, and clinical preparation for the judgement and skills necessary for management and care of primarily healthy women and newborns.

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[85]MANA, Appendix to its Brief to the Health Disciplines Board entitled, "Direct-Entry Training Opportunities", (March, 1990).

[86]Manitoba Advisory Council on the Status of Women, p. 35.

[87]United Kingdom Central Council, p. 4.

TABLE 1

Training Program for Midwives in Countries of the European Community[88]

The training program for obtaining a diploma, certificate or other evidence of formal qualifications in midwifery consists of the following two parts:

A. Theoretical and Technical Instruction

General subjects

1. basic anatomy and physiology
2. basic pathology
3. basic bacteriology, virology and parasitology
4. basic biophysics, biochemistry and radiology
5. paediatrics, with particular reference to newborn infants
6. hygiene, health education, preventive medicine, early diagnosis of diseases
7. nutrition and dietetics, with particular reference to women, and newborn and young babies
8. basic sociology and socio-medical questions
9. basic pharmacology
10. psychology
11. principles and methods of teaching
12. health and social legislation and health organization
13. professional ethics and professional legislation
14. sex education and family planning
15. legal protection of mother and infant

Subjects specific to the activities of midwives

1. anatomy and physiology
2. embryology and development of the fetus
3. pregnancy, childbirth and the puerperium
4. gynaecological and obstetrical pathology
5. preparation for childbirth and parenthood, including psychological aspects
6. preparation for delivery (including knowledge and use of technical equipment in obstetrics)
7. analgesia, anaesthesia and resuscitation
8. physiology and pathology of the newborn infant
9. care and supervision of the newborn infant
10. psychological and social factors of pregnancy and childbirth

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[88]"Training Program for Midwives", Official Journal of the European Communities, No. L33 (February, 1980), p. 11,12.

B. Practical and Clinical Training

This training is to be dispensed under appropriate supervision.

1. Advising of pregnant women, involving at least 100 prenatal examinations;
2. Supervision and care of at least 40 women in labour;
3. The student should personally carry out at least 40 deliveries (where this number cannot be reached owing to the lack of available women in labour, it may be reduced to a minimum of 30, provided that the student participates actively in 20 further deliveries);
4. Active participation with breech deliveries (where this is not possible because of lack of breech deliveries, practice may be in a simulated situation);
5. Performance of episiotomy and initiation into suturing. Initiation shall include theoretical instruction and clinical practice. The practice of suturing includes suturing of the wound following an episiotomy and a simple perineal laceration. This may be in a simulated situation if absolutely necessary;
6. Supervision and care of 40 women at risk in pregnancy, labour or postnatal period;
7. Supervision and care (including examination) of at least 100 postnatal women and healthy newborn infants;
8. Observation and care of the newborn requiring special care including those born pre-term, post-term, underweight or ill;
9. Care of women with pathological conditions in the fields of gynaecology and obstetrics;
10. Initiation into care in the field of medicine and surgery. Initiation shall include theoretical instruction and clinical practice.

Because midwives currently practicing in Alberta are not regulated, there are no formal training requirements that exist for them. However, 67 of the 73 members of the AAM reportedly have a nursing credential, while the rest have some form of direct entry training.[89]

To make this distinction between the members of the AAM is to illustrate the main point of contention with regard to possible midwifery training programs. Some organizations (for example, the College of Physicians and Surgeons of Alberta, the Alberta Society of Obstetricians and Gynaecologists and the Alberta Association of Registered Nurses) feel that, should midwifery become a regulated

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[89]Alberta Health, p. 1.

discipline, it would most appropriately be treated as part of the nursing profession; therefore, midwifery education should be offered only as an advanced specialty of nursing. On the other hand, the AAM and other groups that support midwives believe midwifery is qualitatively different from nursing and, therefore, direct entry (as well as post-nursing) training should be recognized. This view holds that while certain nursing skills are required, it is not necessary for midwives to be fully qualified nurses.[90]

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[90]Manitoba Advisory Council on the Status of Women, p. 35.

IX. SCOPE OF PRACTICE/STANDARDS OF COMPETENCY[91]

A. Scope of Practice

The Midwives Alliance of North America (MANA) is a voluntary association of nurse-midwives and non-nurse midwives in the USA and Canada. Its stated aims are to encourage communication and support among North American midwives, to form an identifiable and cohesive organization to represent these midwives and to foster cooperation between midwives and related professional and non-professional groups.[92] MANA is also involved in developing standards of competency for midwives, and provided an extensive list of "core competencies" for basic midwifery practice as part of its brief to the Board. This list serves well as a description of both the scope and standards of practice for entry-level midwives.[93]

MANA introduced these core competencies by first presenting a framework of guiding principles for the practice of midwifery. They wrote that entry-level midwives must understand and practice according to the following principles:

1. that pregnancy, childbirth, and the puerperium are normal physiological processes;
2. that midwives are autonomous professionals working in collaboration with, and referring clients when appropriate to, other health care and social service providers, including physicians and nurses;
3. that midwives strive to avoid the unnecessary use of interventions;
4. the importance of informed decision-making regarding health care options;
5. the importance of health education, health promotion and self-care;
6. the importance of emotional and psycho-social factors that impact the childbearing cycle and reproductive health;
7. the importance of family centred care;

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[91]In the information submitted to the Board, activities in the scope of practice of midwives were regarded as virtually the same as their standards of competency. Therefore, both these topics are dealt with together in this one chapter.

[92]MANA, Midwifery Brief Submitted to the Health Disciplines Board.

[93]MANA, Appendix to its Brief to the Health Disciplines Board entitled "Core Competencies in Midwifery".

8. the value of quality health care, in particular, continuity of care and accessibility to health care for all women; and
9. the value of maternal, infant and family bonding theory and method.

Along with these principles, MANA believes there is a base of academic and practical knowledge that is integral to all aspects of midwifery. Therefore, the Association believes that entry-level midwives must have a working knowledge of:

1. communication, counselling and teaching techniques, including client education and inter-professional collaboration;
2. human anatomy and physiology relevant to normalcy, changes and pathology in the childbearing cycle;
3. community standards of care, including midwifery and medical standards, for women during the childbearing cycle, and the value of written protocols;
4. community resources for women and children, including but not limited to financial aid, food and shelter, counselling/support groups, transportation, child care and health services;
5. significance of and methods for thorough documentation of client care through the childbearing cycle, including the appropriate medical terminology and abbreviations; and
6. clean and aseptic techniques, and universal precautions.

The core competencies of midwives were grouped according to whether they occurred during the antepartum, intrapartum or postpartum stages of care, during care of the newborn, or during family planning and well-women care.

In each of these phases of care, the core competencies were presented as a "foundation of skills and/or knowledge (where ability to perform appropriate skills is implicit in knowledge). Furthermore, MANA prefaced each of the following sets of competencies with the statement "(an) entry-level midwife assumes responsibility for providing the appropriate health care, support and information ... and (recognizes and assesses risk factors) to determine the need for consultation and referral."

Therefore, during antepartum care of women (i.e., from conception to the onset of labour), core competencies are knowledge of and/or skills in

1. preconceptional factors likely to influence pregnancy outcome (e.g., family, health and obstetrical history);
2. clinical application of genetics and embryology;
3. anatomy and assessment of the bony pelvis;
4. identification and assessment of the normal changes of pregnancy;

5. parameters and methods of assessing the progress of pregnancy, fetal growth and position;
6. nutritional requirements for pregnant women and methods of nutritional assessment and counselling;
7. environmental and occupational hazards for pregnant women;
8. education and counselling to promote health throughout the childbearing cycle;
9. methods of diagnosing pregnancy;
10. the physiology, treatment and appropriate referral for common discomforts of pregnancy;
11. assessment of physical status based on laboratory data (e.g., from blood tests and urinalysis) and relevant historical data;
12. planning with each client and her family or significant others for the birth experience;
13. indications for, and risks and benefits of, screening (diagnostic) tests used during pregnancy;
14. etiology, assessment, treatment and appropriate referrals for abnormalities of pregnancy;
15. implications and appropriate treatment for various STD/vaginal infections during pregnancy;
16. special needs of the Rh negative woman;
17. assessment and appropriate referral of illnesses during pregnancy; and
18. identification and management of the HIV positive woman.

During intrapartum care of women (stages 1 through 4), midwives must conduct deliveries on their own responsibility and manage the immediate postpartum period; therefore, they must demonstrate knowledge of and/or skills in:

1. normal labour processes, including the mechanisms of labour and birth;
2. anatomy of the fetal skull and its critical landmarks;
3. parameters and methods of assessing maternal and fetal status including relevant historical data (e.g., perform vaginal examinations to determine the state of the cervix and the membranes, and auscultate the fetal heart);
4. parameters and methods of assessing and managing the progress of labour and delivery, stages 1 through 4 (e.g., assess strength, frequency and duration of uterine contractions, and palpate the abdomen to determine lie, presentation, position and descent of the fetus);
5. emotional changes during labour and delivery;
6. comfort and support measures during labour, birth and immediately postpartum;
7. techniques for spontaneous vaginal delivery;
8. techniques for placental expulsion (i.e., observe for signs of separation of the placenta, deliver the placenta and membranes, and manage postpartum hemorrhage);

9. etiology, assessment, appropriate referral/transport and/or emergency measures (when indicated) for the mother or neonate for abnormalities of the four stages of labour;
10. anatomy, physiology, indicators and methods of supporting normal adaptation of the newborn to extrauterine life (e.g., clear and maintain a patent airway for the newborn, determine Apgar scores, perform resuscitation procedures (if required), etc.);
11. indications for medical interventions and technologies used during labour and birth;
12. appropriate emotional and physical support to the labouring women and her significant others; and
13. assessment and appropriate management of the perineum and surrounding tissues (e.g., perform episiotomies and repairs to the perineum as required).

During postpartum care of women (i.e., the first ten days after birth), midwives' core competencies are knowledge of and/or skills in:

1. anatomy and physiology of the postpartum period, including the involutional process;
2. anatomy and physiology of lactation and methods for its facilitation or suppression, and appropriate breast care and assessment;
3. parameters and methods for assessing and promoting postpartum recovery;
4. etiology and methods for managing the discomforts of the puerperium;
5. emotional/psychosocial/sexual changes postpartum;
6. nutritional requirements for lactating and non-lactating women during the postpartum period;
7. etiology, assessment, treatments and appropriate referral for abnormalities of the puerperium; and
8. state/provincial laws regarding filing of birth certificates.

In caring for the newborn and providing support to parents during the neonatal period (i.e., first four weeks after birth), basic competencies include knowledge of and/or skills in:

1. anatomy and physiology of the newborn's adaptation to extrauterine life in the first hours and days;
2. parameters and methods for assessing the newborn's status, including relevant historical data;
3. parameters and methods for assessing gestational age of the newborn;
4. nutritional needs of the newborn and nutritional content of breast milk and infant formulas;
5. community standards and state (provincial) laws for, and administration of, prophylactic treatments commonly used during the neonatal period;

6. community standards, indications, risks and benefits and methods of performing common screening tests on the newborn;
7. etiology, assessment, emergency measures and appropriate transport/referral of neonatal abnormalities; and
8. methods to assess the success of the breast feeding relationship, identifying lactation problems and making appropriate referrals.

In matters of women's reproductive health and family planning, midwives' core competencies include knowledge of and/or skills in:

1. psychosocial and physical components of human sexuality, including indicators and common problems and methods of counselling;
2. steroid, mechanical, chemical, physiological, and surgical conception control methods;
3. issues involved in decision-making regarding unplanned pregnancies, and resources for counselling and referral;
4. etiology, assessment, treatments and appropriate referral of abnormalities of the reproductive system and breast;
5. methods of pregnancy testing on urine and blood; and
6. assessment of physical status, including relevant historical data.

Contrary to these last requirements of MANA, the Ontario Task Force on midwifery did not find any evidence of a need for midwives to provide well-women gynaecological care. The Task Force noted that in Ontario such care is provided by physicians, and recommended that the activities within midwives' scope of practice relate primarily to the reproductive cycle (i.e., in practical terms, that a midwife's care of any one client begin during early pregnancy and end at about six weeks after birth).[94]

The AARN and the ACNM also provided lists of basic competencies for midwives (or nurse-midwives in the case of the ACNM list) along with their briefs to the Board. There were essentially no competencies, or areas of competency, in the lists of these two associations that were not included in the list from MANA, with one exception. MANA made no specific mention of knowledge or use of medications in its list whereas:

- the AARN stated that assessing the need for effective relief of pain and administering appropriate medications, along with knowledge of drugs, routes of administration and modes of action, were basic competencies of midwives. They also wrote that midwives must be able to start intravenous infusions in emergency situations; and

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[94]Ontario Task Force on Implementation of Midwifery, p. 86.

- the ACNM wrote that knowledge and/or skills in the pharmacology, prescription and administration of medications and solutions commonly used during pregnancy, labour, birth and the puerperium were basic competencies of nurse-midwives.

Even though these additional competencies were put forth by organizations that endorse nurse-midwives (as opposed to non-nurse midwives), administration of medications is not generally regarded as a prerogative of nurse-midwives. For example, in the United Kingdom, all midwives are permitted to obtain and administer certain controlled drugs, and community midwives may, subject to local rules, carry sedatives, analgesics, local anaesthetics, anti-haemorrhagic preparations and agents for neonatal and maternal resuscitation.[95] In addition, the Ontario Task Force on the Implementation of Midwifery advised that midwives be allowed to administer medications on their own authority, including anti-haemorrhagic agents, local anaesthetics and other medications.[96]

B. Conditions of Practice

Apart from commenting on the knowledge and skills that should make up the scope of midwifery practice, many respondents expressed views on conditions of practice for midwives. The AAM wrote that midwives must be allowed to practice independently within a scope of practice that is consistent with the World Health Organization's definition of midwifery; they must be allowed to exercise independent clinical judgement and take full responsibility for managing pregnancies and births under their primary care.[97] However, midwives also acknowledge that the interests of childbearing women and their babies are best served only when midwives can rely on the co-operation and support of other health care professionals if a need for their services arises. Therefore, along with maintaining independent practices, midwives seek to establish formal working relationships with other health care professionals; most importantly, they want to establish a relationship with physicians that is collegial and collaborative in matters of maternity care.[98]

Physicians' associations that submitted briefs had a different view of the possible relationship between physicians and midwives. None

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[95]Ontario Task Force on Implementation of Midwifery, p. 58,59.

[96]Ontario Task Force on Implementation of Midwifery, p. 86.

[97]Ontario Task Force on Implementation of Midwifery, p. 86.

[98]AAM, Midwifery Brief Submitted to the Health Disciplines Board.

of these associations feel that physicians should actually supervise midwives; however, none of them advocate midwives as fully-independent practitioners either. Instead, these associations advised that, if midwives become regulated, they should be hospital employees directly accountable to authorities in obstetrics and nursing. In contrast, if midwives were independent practitioners (and part of an autonomous, self-regulating profession), they would presumably be accountable firstly to their patients and professional association.[99]

Along with accountability, access to midwifery services is another point of contention related to independence of practice. In general, physicians' associations proposed that access to midwives should only be through a referral from a physician. However, supporters of independent midwifery practice (most notably the Alberta Midwifery Task Force and the University of Alberta Faculty of Nursing) recommended that access be either direct or by referral. Interestingly, the College of Physicians and Surgeons remarked that direct access may be acceptable if it occurs in hospitals where midwives provide services that are managed by physicians.

Another aspect of the question of accessibility is whether a childbearing woman should be required to consult with a physician at various times during her pregnancy. Typically in midwifery care systems in Europe, a woman must be examined by a physician at prescribed times during her pregnancy. An initial examination is done to diagnose any medical problems and to determine whether it is appropriate for her to be cared for by a midwife. Later in the pregnancy, a second consultation serves to check the woman's overall health and to review the status of her pregnancy. In some cases, medical visits also provide access to prescription medications, tests, services, and procedures for which the authority of a physician is needed.[100]

One of the recommendations of the Ontario Task Force on Midwifery was that standards of midwifery practice specify at least two mandatory medical visits for a woman during pregnancy - the first to occur as early as possible in the pregnancy, and the other at 32 to 34 weeks after conception.[101] The Alberta Medical Association and the Alberta Association of Obstetricians and Gynaecologists made similar recommendations in their briefs; neither the AAM nor any of their supporters addressed this particular point.

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[99]University of Alberta Faculty of Nursing, Midwifery Brief Submitted to the Health Disciplines Board.

[100]Ontario Task Force on Implementation of Midwifery, p. 87.

[101]Ontario Task Force on Implementation of Midwifery, p. 87.

The initial consultation with a physician would be essentially to determine whether a pregnancy and birth are suitable to be managed by a midwife. The AAM stated in the brief that such pregnancies would be "(primarily) healthy, low-risk pregnancies, (which are) expected to (result in) uncomplicated deliveries." Therefore, criteria must be established to distinguish between pregnancies that are healthy and low-risk, and those that are not. For reference, an account of the criteria used to make this distinction in the Netherlands is presented in Appendix 3: "List of Indications for Specialist Care in The Netherlands".

Midwives must be able to evaluate the course of a pregnancy and delivery, and detect any deviations from the norm that require medical attention. Therefore, the criteria used to determine initially a woman's suitability for midwifery care also serve to determine which women must be referred from midwives back to an obstetrician.

In their brief, the AAM made no mention of such criteria, but did write that "arrangements with physicians for consultation and referral" must be established. Moreover, they noted that midwives should be allowed to continue to take part in caring for women they refer to physicians for more specialized care.[102]

The most contentious issue in the midwifery debate is whether midwives should be allowed to attend planned home births. Midwives do not conduct deliveries solely in women's homes; they also practice in hospitals, clinics, health units, and other facilities.[103] In fact, the AAM did not specifically mention home births in their brief; instead, they requested the privilege to practice in "both hospital and other settings." Even so, virtually all midwives (and their supporters) contend that attending home births is an integral part of the practice of midwifery.[104]

All of the physicians' associations that submitted briefs, along with the AARN, are opposed to home births. These organizations contend that life-threatening complications can arise unexpectedly during childbirth, and these complications can be dealt with more easily and effectively in a hospital than in a woman's home. Furthermore, complications that necessitate hospital-based medical

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[102]The Ontario Task Force on Midwifery recommended also that provisions be made to enable physicians to delegate medical acts to midwives who help tend to pregnancies or deliveries that a physician has assumed responsibility for.

[103]Manitoba Advisory Council on the Status of Women, p. 12.

[104]Ms. S. Pullin of the Edmonton Midwifery Group, quoted in "Midwives go for recognition", Edmonton Journal (September 16, 1990), p. B1.

procedures could be dealt with more quickly if birth is already being managed in a hospital (i.e., there would be no time spent transferring the patient(s) from home to hospital).

Several organizations, including the AARN, proposed establishing alternate birthing centres for women who are inclined to give birth at home. The AARN envisages these alternate birthing centres as

> "... rooms or units located in a hospital or in close proximity to a health care facility. (They would be) furnished in a home-like style if possible, with a bed that can be used during labour and delivery. The atmosphere (would be) relaxed and allow for family participation. Transport facilities (would be) available for immediate transfer of mother and baby to a well-equipped obstetrical unit should an emergency occur."[105]

The issue of childbirth in women's homes is discussed more fully in the next chapter on assessment of risk.

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[105]AARN, Appendix to its Brief to the Health Disciplines Board entitled, "Position Statement on Alternate Birthing Centres" (December, 1982).

X. RISK TO THE PUBLIC

Every organization that addressed the issue of risk advised that the risks inherent in the practice of midwifery warrant some form of regulation (although not necessarily under the Health Disciplines Act). Regulation was invariably viewed as necessary to ensure the competency of midwives and, consequently, protect the public who choose to use their services.

The College of Physicians and Surgeons stated that the risks involved in the practice of midwifery arise primarily from the "development of (any) abnormal feature in maternal health, obstetrical status, the progress of labour, or the condition of fetus or newborn." Therefore, midwives would have to be able to recognize abnormal developments during pregnancy and childbirth, and take appropriate measures to ensure that the mother and/or infant receives proper medical treatment.[106] Failure to do so could result in injury or even death to a mother or her baby.[107]

In order to minimize such risks, midwives screen their clients and accept primary responsibility for only "low-risk" pregnancies which are expected to lead to uncomplicated deliveries. The AAM also contends that properly trained and regulated midwives are able to monitor pregnancies and childbirth and make appropriate referrals when necessary. They seek to establish formal arrangements with physicians and hospitals for backup services for potential medical emergencies. However, midwifery must legally sanctioned before such arrangements can be made.

The most controversial point with respect to risk is whether midwives should be allowed to attend planned home births. Several respondents argued that risks associated with home births are so severe that this area of midwifery practice should not be allowed. In Alberta, a physician's preplanned attendance at a home birth is considered unbecoming conduct and could lead to loss of license.[108] Accordingly, all the physicians' associations that submitted briefs (along with the AARN) are opposed to childbirth occurring in women's homes. Their main concern is that necessary medical facilities and personnel would not be immediately available should an emergency situation arise.

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[106]See Appendix 3: "List of Indications for Specialist Care in The Netherlands" for an account of these abnormal developments.

[107]Alberta Health Occupations Board, p. 33.

[108]Alberta Health, p. 5.

However, proponents of midwifery generally regard assisting at home births an integral part of the practice of midwifery. They feel the risks associated with birth at home are not prohibitive and that properly informed parents must be allowed to choose this option. Some supporters of midwifery have even claimed that midwife-attended home births are safer than physician-attended hospital births for certain (i.e., low-risk) pregnancies, citing the prevalence of medical interventions in hospital births and complications that could result from these interventions.[109]

Many studies have been carried out on the relative safety of home births and hospital births. A review of the scientific literature on this topic was published in the British Journal of Obstetrics and Gynaecology in 1986, and cited in the Report of the Task Force on the Implementation of Midwifery in Ontario. The conclusion of this review was that evidence to support claims that either hospitals or homes are safer settings for birth is inconclusive. Furthermore, the available evidence suggested that the statistical association between the increase in the proportion of hospital births and the decline in the perinatal mortality rate (over the past several decades) is not wholly or even mainly explained by a cause and effect relationship.[110]

One of the major reasons for the inconclusiveness of available evidence is that methodological problems are inherent in studies of the relative safety of home and hospital births. For example, data from these two settings may not be entirely comparable:

- data on home births can include unplanned (precipitous) births and cases of women who give birth at home against the advice of physicians or midwives; and

- women considered to have higher-risk pregnancies are normally restricted to having their babies in hospitals.

Other variables that can confound the data from these studies are the health and obstetrical histories of the women, the amount and quality of care the receive during pregnancy, and selection biases of the women themselves.[111]

No definite conclusion is apt to be drawn from scientific literature about the extent to which place of birth influences outcome. Nevertheless, a national consulting firm, Peat Marwick

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[109]Ontario Task Force on Implementation of Midwifery, p. 109.

[110]R. Campbell and A. Macfarlane, "Place of Delivery: A Review", British Journal of Obstetrics and Gynaecology 93 (1986), pp. 675-683.

[111]Ontario Task Force on Implementation of Midwifery, p. 109.

Stevenson & Kellogg, was contracted by the Health Disciplines Board to do an impartial review of the literature on this subject published since 1986, and either reaffirm an refute the findings presented in the British Journal of Obstetrics and Gynaecology article cited previously. The findings were essentially reaffirmed; the consultants found no conclusive evidence to support the view that giving birth at home is significantly less safe than giving birth in hospital for carefully selected and properly attended women.

Beyond merely comparing rates of mortality and morbidity, the consultants were asked to look for more substantive information on (i.e., recurring causes of) maternal/perinatal deaths and illnesses in both homes and hospitals. An account of why these deaths and illnesses occur might serve as a useful illustration of the nature and relative seriousness of the risks associated with the practice of midwifery and, in particular, home births. The consultants were not able to provide this information. However, the "Edmonton Midwifery Group Home Birth Statistics, 1980 - 1989" are helpful in this regard and so are appended for reference (see Appendix 4).

Judging from the statistics of the Edmonton Midwifery Group and the submissions from individual citizens to this investigation, home births are common in Alberta. They are likely to continue regardless of the prevailing opinions among associations of physicians and nurses. The question remains, then, whether an arrangement can be reached that would allow midwives to attend home births, and would ensure medical back-up for home births.

XI. SUMMARY OF ORAL PRESENTATIONS

Every organization that submitted a written brief to the Board's investigation was invited to make an oral presentation to the Board. Fourteen organizations made oral presentations, as did four individuals who had written letters to the Board.

In general, the oral presentations were a restatement and explanation of views submitted previously in written briefs. Several noteworthy points were made during the presentations and, in two instances, an organization's representatives stated a position that differed from what was presented in its written brief. The salient points of the oral presentations are summarized below.

Three physicians' associations (Alberta Medical Association, College of Physicians and Surgeons and College of Family Physicians of Canada - Alberta Chapter) made oral presentations to the Board. Representatives from the Alberta Medical Association (AMA) stated that Alberta has an exceptionally low perinatal mortality rate compared to nations world-wide, and stressed that the quality of maternity care existing now in the province must not be compromised by incorporating midwives into the health care system. They also claimed that changes to humanize maternity care are already occurring in Alberta hospitals and in the way physicians provide this care (in the actual procedures used and the manner and surroundings in which they are performed). Therefore, although they would accept hospital-based midwives as members of the maternity care team, they see no need for more drastic changes to the existing system of maternity care, such as permitting midwives to attend planned home births.

A spokesman for the College of Physicians and Surgeons brought up the midwifery pilot project carried out at the Misericordia Hospital between January, 1985 and February, 1986; he remarked that the admission of patients by midwives was found to be a problem during the project. More generally, he stated that no risk scoring system for determining low and high risk pregnancies has yet proven to be "adequate". Another representative added that approximately 15% of pregnancies regarded as low risk develop into high risk cases during pregnancy, labour or delivery. A conclusion they drew from these points was that physicians should perform or oversee initial and intermittent assessments of women who are in the care of midwives, stay advised of the progress of their pregnancies and, therefore, be prepared to admit them into hospital if necessary. The College of Family Physicians spokesmen reiterated that physicians (in particular, family physicians or general practitioners) should function as "gatekeepers" to the health care system for childbearing women.

Both the AMA and College of Physicians and Surgeons argued that a recent trend in European countries has been for midwives to manage deliveries in hospitals rather than in women's homes; all three physicians' associations stressed the importance of having back-up medical services available during labour and delivery.

In her presentation, the Alberta Hospital Association (AHA) representative made a change to a position the AHA stated in its written brief. Instead of regarding midwifery as "more appropriately" regulated under the Nursing Profession Act, the AHA changed its position to firmly supporting the regulation of midwifery under the Nursing Profession Act.

The AHA representative also stated that the AHA's primary concerns are the health care services offered in their facilities, and these concerns can be dealt with only after more fundamental decisions on legislation and regulation are made.

Representatives from the Alberta Association of Registered Nurses (AARN) spoke primarily of why they believed midwives (i.e., nurse-midwives) should be regulated under the Nursing Profession Act. They remarked that there are too few non-nurse midwives to justify regulating midwifery under any other legislation, and said the Nursing Profession Act provides for special registries in which midwives could be registered. They stated that as specialized practitioners under the Nursing Profession Act, midwives would be able to set their own standards of practise, may be able to establish independent practices, and may be able to get malpractice insurance through their association with the AARN.

The AARN president also stated a change in the Association's position on home births. She said that if midwives have a legal basis for practise, standards of practise, patient selection protocols and arrangements for medical back-up, the AARN would accept them attending planned home births.

Representatives from the University of Alberta Faculty of Nursing disagreed with regulating midwives under the Nursing Profession Act because of the qualitative differences between the work of midwives and nurses. Instead, they believe midwives should be a self-governing group with appropriate involvement of physicians and nurses in governance of the discipline. They also spoke of the midwifery specialization program at the University of Alberta. Six students have graduated from the program, and two students are presently enroled. The Faculty believes that both direct entry and post-nursing training in midwifery should be considered acceptable routes for entry to practise.

Representatives from the Calgary Midwives Collective (CMC) and the Edmonton Midwifery Group (EMG) appeared before the Board. They spoke primarily of their reasons for becoming midwives, their training (three of the four presenters had completed formal

training as registered nurses before beginning their midwifery practices), and what their practices entail.

Midwives from the CMC have not been in active practise since November, 1989; apparently, the time and effort they are spending to gain legislative recognition prevents them from maintaining practices. However, they also remarked that home births are still occurring in Calgary even though trained, experienced midwives are not available to attend them.

In contrast, the EMG is currently in active practise. In fact, the presenters stated that requests for their services have increased recently owing to the publicity they received after one of their members was charged with practising medicine without a license, and that they were each spending approximately 60 hours per week at their work.

The EMG representatives stated that they attend eight to ten births each month, and generally provide 40-50 hours of care to each of their clients. They referred to their cumulative statistics for 1980 through 1989 and noted that they attended nearly 1000 planned home births during this period. Of these, 89.5% were successfully completed in the home, approximately 5% of their home birth clients were transferred to hospital prenatally, and another 5% were transferred during labour.

The EMG representatives remarked that they have informal arrangements with a small number of physicians for certain cases of referral, or when they decide admission to hospital is necessary. They also remarked that they are familiar to Edmonton's ambulance personnel and a spirit of co-operation has developed between the two groups.

Dr. Karyn Kaufman spoke to the Board on behalf of the McMaster University Health Sciences Centre, the site of an ongoing midwifery care project. Dr. Kaufman described the project in detail, and commented that physicians involved in the project are becoming more and more willing to let midwives take complete control of the management of patients in their care.

Dr. Kaufman was a member of the Ontario Task Force on the Implementation of Midiwfery. She remarked that the implementation of midwifery into Ontario's health care system is proceding in accordance with the Task Force's recommendations. For example, an Interim Regulatory Council for midwifery has been established, a proposed Midwifery Act has been introduced in the provincial legislature, and standards of practice and a curriculum for a direct entry training program have been drafted.

The Alberta Association of Midwives (AAM) representatives summarized the benefits to women and to the health care system of granting legislative recognition to midwives. They described the

organizational structure of the AAM and how it would serve well to govern midwifery in the province. They acknowledged that they previously wanted free-standing legislation for midwifery, but emphasized that the Health Disciplines Act is now their preferred choice of legislation, with its openness for input from physicians, nurses and the public into the governance of midwifery.

Four consumers' associations made oral presentations to the Board: the Alberta Midwifery Task Force, the Association for Safe Alternatives in Childbirth, the Calgary Association of Parents and Professionals for Safe Alternatives in Childbirth, and the Vaginal Birth After Cesarean Support Group. These associations were represented by men and women from a broad spectrum of training and employment; however, they all strongly supported the designation and regulation of midwifery. Nearly all of them had either experienced or observed first-hand the care provided by midwives in Alberta; most of the women in these organizations had given birth at home at least once.

For the most part, members of these groups compared and contrasted their experiences (and observations) of giving birth at home and in hospital, attended by midwives or by physicians. All accounts emphasized the comparative benefits of being attended to by midwives but, generally, were not directly critical of the obstetrical services provided by physicians. The relative benefits they spoke of most were:

- the extent and thoroughness of the prenatal care they received;
- the continuity of care they received (i.e., from individual midwives) throughout pregnancy, labour and delivery, and postpartum recovery; and
- the gentle and sensitive manner in which they were cared for, and how midwives paid heed to their requests during labour and delivery.

Four individuals who wrote letters regarding midwifery to the Board accepted an invitation to speak to the Board; all of them supported the designation and regulation of midwifery, as did virtually all of the 242 persons who submitted letters. The first among them was a physician who regularly attended planned home births in and around Edmonton between 1978 and 1981. As part of this practice, he helped train and worked alongside two midwives; he remarked that the midwives worked under his "legal umbrella" during this time. The physician stopped attending planned home births in 1981 after the College of Physicians and Surgeons passed a ruling which prohibited physicians from doing so. However, the midwives (known now as the Edmonton Midwifery Group) continued to attend home deliveries without medical supervision. The physician's involvement with the EMG's practice is now limited to providing medical assistance in the prenatal care of women, and facilitating the admission of these women into hospital if necessary.

The physician outlined the main reasons why women choose to give birth at home, stressed that reliable evidence shows that a properly attended home birth is a safe alternative to a hospital birth, and stated that attending home births is an integral part of midwifery. In addition, he referred to the record of outcomes of the nearly 1000 home births the EMG midwives have attended since 1980 as evidence of the excellent standard of care they provide.

The next two individuals who appeared before the Board discussed their childbirth experiences when attended by physicians and by midwives, and explained why they preferred to be cared for by midwives. The fourth individual presenter (a registered nurse) spoke primarily of an informal survey she conducted of nearly 100 women who had recently given birth in and around Calgary. She stated that the findings of her survey indicate that midwives' services should receive legislative recognition and be made an openly available alternative for childbearing women in Alberta.

XII. RECOMMENDATIONS

As a result of its investigation and deliberations concerning the application of the Alberta Association of Midwives for designation of midwifery under the Health Disciplines Act, the Board recommends that:

1. the degree of risk associated with the practice of midwifery is such that the discipline should be designated under the Health Disciplines Act.

   (Vote: seven agreed, one opposed)

2. registration as a midwife under the Health Disciplines Act should not be restricted to individuals who have a registered nursing qualification.

   (Vote: carried unanimously)

3. a Midwifery Implementation Advisory Committee, which includes representation from the Alberta Association of Midwives, the College of Physicians and Surgeons, the Alberta Association of Registered Nurses, the Alberta Hospital Association and the public, be established to advise the Board on implementation issues.

   (Vote: carried unanimously)

4. home births be included in the scope of practice of midwifery.

   (Vote: seven agreed, one opposed)

5. the multi-disciplinary Midwifery Implementation Advisory Committee advise the Board on conditions and restrictions to be required for midwives' attendance at planned home births, taking into account risk, experience, and access to medical support services.

   (Vote: carried unanimously)

List of Appendixes:

APPENDIX 1:

ORGANIZATIONS CONTACTED AND RESPONSES RECEIVED IN THE MIDWIFERY INVESTIGATION

A. ORGANIZATIONS THAT RESPONDED AND THEIR VIEWS ON LEGISLATION FOR MIDWIFERY

- 1 -

Organization	Support Designation under the Health Disciplines Act?	Further Remarks on Possible Legislation
Alberta Association of Midwives	Yes	None
Association of Ontario Midwives	Yes	None
American College of Nurse - Midwives, USA	Abstained	None
Midwives Alliance of North American, USA	Yes	None
Royal College of Midwives, UK	Yes	None
Netherlands Midwifery Association	Yes	Prefer independent legislation
International Confederation of Midwives, UK	Yes	Prefer independent legislation
Alberta Society of Obstetricians and Gynaecologists	No	If necessary midwifery should be regulated under the Nursing Profession Act
College of Family Physicians of Canada - Alberta Chapter	No	None
College of Family Physicians of Canada - Ontario Chapter	No	None
College of Physicians and Surgeons of Alberta	No	May accept nurse-midwifery under Nursing Profession Act
Alberta Medical Association	Abstained	Suggested midwifery may be regulated under the Medical Profession, Nursing Profession or the Health Disciplines Act
International Confederation of Obstetrics and Gynaecology, UK	Yes	None

Organization	Support Designation under the Health Disciplines Act?	Further Remarks on Possible Legislation
Alberta Association of Registered Nurses	No	Would accept nurse-midwifery under the Nursing Profession Act
Professional Council of Registered Nursing Assistants of Alberta	Yes	Only as a post-basic specialty of nursing
Alberta Prehospital Professions Association	Yes	None
Alberta Association of Social Workers	Yes	None
Alberta Hospital Association	No	May accept nurse-midwifery under the Nursing Profession Act
United Kingdom Central Council for Nursing, Midwifery and Health Visiting, UK	Yes	None
University of Alberta Faculty of Nursing	Yes	Prefer Independent legislation
University of Calgary Faculty of Nursing, Alberta	No	Would accept nurse-midwifery under the Nursing Profession Act
Grande Prairie Regional College, Alberta	Abstained	None
Grant MacEwan Community College, Alberta	No	Prefer nurse-midwifery regulated under the Nursing Profession Act
Lethbridge Community College, Alberta	Yes	None
Medicine Hat College, Alberta	Yes	None
Mount Royal College, Calgary, Alberta	Abstained	None
Red Deer College, Alberta	No	Prefer regulation of midwifery under the Nursing Profession Act
Misericordia Hospital School of Nursing, Alberta	Undecided	None

Organization	Support Designation under the Health Disciplines Act?	Further Remarks on Possible Legislation
Fraser Valley Childbirth Education Association Midwifery School	Yes	None
Faculty of Nursing, McMaster University, Ontario	Yes	None
Northern Arizona School of Midwifery, USA	Yes	None
Alberta Health	Yes	None
Alberta Family and Social Services	Abstained	None
Alberta Advanced Education	Abstained	None
Alberta Career Development and Employment	Yes	None
Alberta Women's Secretariat	Yes	None
Alberta Advisory Council on Women's Issues	Yes	None
British Columbia Ministry of Health	Abstained	None
Saskatchewan Department of Health	Abstained	None
Manitoba Health Services Commission	Abstained	None
Ontario Ministry of Health	Yes	None
Ontario Advisory Council on Women's Issues	Yes	None
Quebec Minister des Affaires Sociales	Abstained	None
Office des Professions du Quebec	Yes	None
New Brunswick Department of Health	Abstained	None
Nova Scotia Department of Health	Abstained	None
Prince Edward Island Department of Health	Abstained	None
Newfoundland Department of Health	Abstained	None

Organization	Support Designation under the Health Disciplines Act?	Further Remarks on Possible Legislation
Northwest Territories Department of Health	Abstained	None
Northwest Territories Department of Justice	Abstained	None
Association for Safe Alternatives in Childbirth, Alberta	Yes	Prefer independent legislation
Calgary Association of Parents and Professionals for Safe Alternatives in Childbirth, Alberta	Yes	None
Edmonton Childbirth Education Association, Alberta	Yes	None
Alberta Midwifery Task Force	Yes	Prefer independent legislation
Vaginal Birth After Caesarean Support Group, Alberta	Yes	None
Midwife Task Force of British Columbia	Yes	None
International Childbirth Educators Association, USA	Yes	None
Women's Health Resource Centre, Grace Hospital, Calgary	No	May accept nurse-midwifery regulated under the Nursing Profession Act
Young Women's Christian Association, Calgary	Yes	None
Pauktuutit, Inuit Women's Association, Ottawa	Yes	None
Calgary Midwives Collective	Yes	Prefer independent legislation
Enlightened Childbirth Association, Fort McMurray	Yes	None

B. ORGANIZATIONS THAT WERE CONTACTED BUT DID NOT RESPOND

Midwives Association of British Columbia
Canadian Confederation of Midwives
Association of Radical Midwives, UK
Alliance quebecoise des sages-femmes practitioners, Quebec
Association des sages-femmes du Quebec, Quebec
Independent Midwives Association, UK
Alberta Association of Emergency Medical Services Physicians
Canadian Medical Association
Society of Obstetricians and Gynaecologists of Canada
American Board of Obstetrics and Gynaecology, USA
American College of Obstetricians and Gynaecologists, USA
Victorian Order of Nurses
World Health Organization, Switzerland Alberta
Keyano College, Fort McMurray, Alberta
Foothills Hospital, Calgary, Alberta
Royal Alexandra Hospital School of Nursing, Alberta
School of Nursing, University of Alberta Hospitals
Seattle Midwifery School, U.S.A.
Dorset Midwifery School, U.K.
Medical Services Branch, Health & Welfare Canada
Ontario Women's Directorate
Yukon Territory Department of Health and Human Resources
Alberta Status of Women Action Committee
Central Alberta Childbirth Educators Association
Canadian Institute of Child Health, Canada
National Action Committee on the Status of Women, Canada
Consumers' Association of Canada
National Association of Women and the Law, Canada
R.E.A.L. Women of Canada
National Council of Women, Canada
Task Force on the Implementation of Midwifery in Ontario
Saskatchewan Association of Safe Alternatives in Child Birth
National Perinatal Epidemiology Unit, U.K.
College of Family Physicians of Canada
Department of Obstetrics and Gynaecology, University of Alberta
Department of Obstetrics and Gynaecology, University of Calgary
Royal Alexandra Women's Hospital, Reproductive Health Clinic, Edmonton
Young Women's Christian Association, Edmonton

APPENDIX 2

Summaries of the Briefs of Selected Alberta Respondents

This appendix presents a summary of the views of selected, Alberta-based organizations (both government and non-government) on the major issues that have arisen in this investigation.

The summaries are limited to Alberta-based organizations because:

a) they are the ones expected to be most active in trying to achieve their goals and demands concerning midwifery, and
b) they will be the ones affected most by the outcome(s) of this investigation.

The summaries vary in length and content depending on the information each organization submitted to the Health Disciplines Board. In each, however, positions on three main questions have been outlined (if possible):

a) should midwifery be designated under the Health Disciplines Act and, if not, should it be regulated under some other statute?
b) what training should be required of practitioners? and
c) what should the basic parameters of midwifery practice be (e.g, degree of independence, settings for deliveries, accessibility to patients, etc.)?

The wording of these summaries reflects (as much as possible) the terms and wording found in the briefs.[112] As a cautionary note, though, comments on midwives' practices and prospective training programs from groups that oppose designation of midwifery should perhaps be considered as speculation rather than steadfast views.

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Alberta Association of Midwives

The Alberta Association of Midwives (AAM) would like midwifery to be designated under the Health Disciplines Act. They believe midwifery should be an autonomous, self-regulating profession with its own legislative base.

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[112]A concern arises here over the use of the word "patient". It is used in the summaries but only for the sake of convenience of referring to a childbearing woman. It is not intended to imply that pregnancy is a state of illness or an abnormal physiological state, as many respondents to this investigation strongly disagree with this notion.

The Association's only comment on a prospective training program was that it must have a "direct entry mode", and advanced standing may be granted to students who already have certain post-secondary education.

The AAM stated that midwifery must be fully integrated into the health care system. The Association believes midwives should be allowed to practise in both hospital and "other settings", and cooperative, collaborative relationships must be established between midwives and other health care professionals, primarily physicians and nurses.

The AAM stated that midwives should have their own specific scope of practice, and autonomy within that scope of practice. They remarked that midwives' primary clients are women with healthy, low-risk pregnancies who are expected to have uncomplicated deliveries. However, they added that midwives should be allowed to participate in the maternity care of women who are being attended by physicians.

College of Physicians and Surgeons of Alberta

The College opposes designation as it does not believe that a need for midwives, as distinct from other professionals, has been demonstrated. If another group of practitioners is given the authority to practice midwifery, these practitioners should be suitably trained registered nurses (Rns); correspondingly, the practice should then be regulated under the Nursing Profession Act.

As mentioned, the College would prefer that midwives have an initial Registered Nursing or Bachelor of Science in Nursing credential, and supplement this with a minimum of two years of specialized training in midwifery. They are not in favor of direct entry training programs but, if established, feel these programs should be at least three years in duration. The College also feels that continuing education and periodic demonstrations of competence should be required for midwives.

The College is opposed to midwives practicing independently; instead, they should be hospital employees fully integrated with doctors and nurses, and accountable to authorities in obstetrics and nursing. In addition, midwives would be uniquely entitled to order certain lab exams, medications and ultrasound exams in specified situations. Access to midwives should (generally) be by way of referral from a physician; however, direct access to a midwife may be acceptable if it occurs in a hospital where midwives provide antenatal and delivery services that are managed by physicians.

The College acknowledges an "appetite" among some women for home births. Nevertheless, they are opposed to births occurring outside of hospitals and (perhaps) related birthing clinics due to the possibility of emergency situations arising.

The College believes that midwives should be paid from a hospital's global budget and not be allowed to bill patients directly. They added that malpractice insurance for midwives will be an important issue to the College if midwives become regulated.

The College also noted that physicians (like midwives) are intent on decreasing medical interventions in low risk pregnancies and deliveries.

Alberta Medical Association (AMA)

The AMA did not answer the question on designation. Instead, it stated that midwifery could be introduced into Alberta's health care system, but such a change must be shown by fact to improve present standards of obstetrical care. They added that midwifery would need close regulation under either the Health Disciplines Act, the Nursing Profession Act or the Medical Profession Act.

The AMA feels that an appropriate training program would be a four-year, university-based baccalaureate program that includes clinical experience. The program would parallel or include much of the training that RNs receive. They added that a nursing credential would be desirable but not mandatory for midwives.

The AMA thinks midwives should be independently responsible for women in their care (i.e., they should not require supervision). However, they should be restricted to caring for women with low-risk pregnancies. Physicians would assess and refer patients to midwives, and would help monitor pregnancies by doing two or three check-ups on each patient. Physicians would also provide consultation and full backup services as required. The AMA sees no need for midwives to be involved in gynecological care.

The AMA believes that midwives should be employees of hospitals, and paid as such. They would be directly accountable to authorities in obstetrics and nursing as well as to their patients and the hospital. Deliveries would have to take place in accredited hospitals although antenatal and post-partum care could occur in a clinic or home settings as well as in hospitals.

The AMA remarked that midwives' services should not be instituted in Alberta simply because they are used in virtually all other countries world-wide. Furthermore, they are concerned that statistics on outcomes of home births may be used to compare to those of hospital births. They wrote that such comparisons may not be valid because hospital data would include higher risk deliveries and intended home-births that had to be transferred to hospitals because of complications.

Alberta Society of Obstetricians and Gynecologists

The Society opposes designation for the following reasons:

a) in accordance with a Canadian Medical Association guideline, they feel that another health care occupation (midwifery) should be established only when a need for that occupation has been demonstrated, and the possibility of using already-established personnel to fulfil the need has been ruled out. Furthermore, they note that the Canadian College of Family Physicians has stated that it wants obstetrics emphasized more in training programs for family physicians which would thereby reduce any need for midwives' services; and

b) they see designation as a "potentially regressive" step that would result from failing to address certain weaknesses in the present system of obstetrical care. They claimed that low fees for maternity care, expensive liability insurance, and lack of regard for disruptions to the lifestyles of physicians practicing obstetrics have led to decreases in the numbers of obstetricians and family physicians who practice obstetrics. In turn, the decreases in numbers of practitioners have made it difficult to improve standards of obstetrical care.

The Society conceded that if midwifery services are deemed necessary, they should be regulated under the Nursing Profession Act.

The Society would recommend that midwifery training be a post-basic RN program lasting at least two years. The practical training for midwives, they stress, must not be carried out at the expense of obstetrical training for physicians.

The Society feels that midwives should not be allowed to practice independently. Moreover, they stated that midwives' services should be provided only in hospitals where support from physicians is immediately available. Patients would be referred to midwives by physicians, and physicians would also do intermittent (two or three) check-ups on patients. For their part, midwives would be accountable to, but not directly supervised by, authorities in the departments of obstetrics and nursing.

The Society thinks that incorporating midwives' services into Alberta's health care system may be very expensive, and may not be justified by improvements in standards of care. Conversely, standards of care must not be allowed to decline even if using midwives' services proves to be a less costly form of care. In addition, the Society believes that malpractice insurance may become more complicated and expensive if midwives assume certain responsibilities of physicians.

College of Family Physicians of Canada - Alberta Chapter

The College opposes designation on the grounds that the need for midwives' services has not been demonstrated, and all their services can be provided by family physicians. Designation of midwifery would therefore lead to a duplication of services and further fragmentation of the health care system. They conceded, however, that if a need for midwives can be demonstrated, and their services can maintain (and preferably improve) the present standards of care in a cost-effective way, they would accept designation.

The College feels that the training program for midwives should be a post-basic RN program lasting at least one year. They noted, though, that practical training for midwives will stretch caseloads and detract from the obstetrical training for physicians.

The College feels that midwives should work in a collaborative way with physicians (e.g., physicians would assess and refer candidates for midwife-assisted deliveries). Physicians would not provide direct supervision of midwives (and therefore avoid the liability implications), but they would conduct some scheduled examinations of the patient, and assume the care of emergency or abnormal cases. The College does not approve of home births under any circumstances; midwives would have to provide their services in an accredited facility.

Notably, the College believes that family physicians should be the "gatekeepers" of the health care system. As such, the family physician would be the entry point and co-ordinator of most aspects of health care, including making referrals to other practitioners. In addition, the College believes that obstetrical care should be part of the ongoing care provided by family physicians to their patients. If midwives are integrated into the system, however, the College foresees a diminished role for family physicians (especially in obstetrics), a setback to the continuity of care they provide, a more fragmented health care system, and a likely increase in health care costs.

Alberta Association of Registered Nurses (AARN)

The AARN opposes designation; they may, however, accept nurse-midwifery as a distinct discipline regulated under the Nursing Profession Act. To help clarify their position, they explained that they see midwifery as an extension of nursing; therefore, they would rather that RNs be trained and permitted to practice midwifery than have midwives become established as a separate group.

The AARN recommended that training programs in midwifery be open to RNs only. The programs would last at least one year and be at the post-baccalaureate or Masters level. Alternatively, they speculated that a direct entry program would have to be a four-year

university program that provided the equivalent of a nurse-midwife's training.

The AARN feels that nurse-midwives could have an independent role, but still be fully integrated, in the health care system. They are against the idea of home-births because they consider the inherent risks (e.g., sudden onset of complications, time and distance of transfer, etc.) and the expense of providing backup services too great. They do, however, support the use of birthing centres in or near hospitals for low-risk deliveries.

In summary, the AARN feels midwives' services would largely duplicate existing services. Therefore, the costs of instituting midwives into the health care system (money, upheavals, etc.) could not be justified, especially in view of economic constraints in post-secondary education and health care, and the capabilities of other personnel.

Professional Council of Registered Nursing Assistants (PCRNA)

The PCRNA supports designation but only if midwifery is regarded as a specialized discipline for RNs. (No mention was made, however, of regulation under the Nursing Profession Act).

The PCRNA wrote nothing specific about prospective training programs for midwives, but did remark that a separate (direct entry?) program for them would not be an effective use of resources.

Alberta Hospital Association (AHA)

The AHA opposes designation. They feel that midwifery is a component of nursing and, as such, should be regulated under the Nursing Profession Act if at all.

The AHA stated that if midwifery becomes recognized as a separate discipline, the training program for midwives should be a post-basic nursing program.

The Association concluded by noting the investigation was on midwives, not nurse-midwives, and stating that practitioners not registered with the AARN should not be licensed to practice. They also noted that hospital-based midwifery programs have been pilot tested in Alberta, and should be tested further.

Alberta Midwifery Task Force

The Task Force supports designation but would prefer free-standing legislation. It stated that legislation is necessary to ensure proper standards of practice as well as to support and protect midwives.

The Task Force simply stated that it supports the position of the Alberta Association of Midwives on training programs, but added that knowledge of educational theory (counselling) should be one of midwives' basic competencies.

The Task Force believes that midwives should be independent practitioners subject to their own licensing and regulatory agencies. They feel that, in addition to midwives' expected duties, they should be allowed to order diagnostic tests, order and administer certain medications, perform episiotomies and suture. Access to midwives should be either direct or by referral.

Contrary to the College of Family Physicians of Canada, the Task Force wants midwives to be the gatekeepers to the health care system for childbearing women who wish to use midwives' services. They believe that midwives can provide a "greater margin of safety" for women in normal childbirth because they provide more continuous and direct care.

Misericordia Hospital

The Misericordia Hospital is undecided about whether midwifery should be designated.

The Hospital made no specific remarks about training programs, but did state that more education in the area of maternal/newborn nursing is needed.

The Hospital believes that midwives should be integrated into the health care system to facilitate consultations with, and referrals to, physicians. The scope and settings of practice for midwives should determine how independently they are allowed to practice. Even so, they advise that deliveries should be carried out only in hospitals or birthing centres near hospitals.

The Hospital acknowledges that labor/delivery nurses provide nearly all the care for childbearing women, and sometimes even manage the delivery of babies (i.e., when the delivery proceeds without complication). They added that duplication of services to childbearing women by different groups of personnel may seem bad, but instead may lead to enhanced service and better cost effectiveness. Finally, the Hospital remarked that post-partum care required more improvement than labor and delivery services.

University of Alberta (Edmonton) Faculty of Nursing

The Faculty supports designation for the reasons of protecting the public and ensuring the availability of midwifery services. They add, however, that free-standing legislation for midwives would engender more independence, professional responsibility, and collegiality with other members of the health care team (i.e.,

physicians and nurses). In short, the Faculty believes that midwifery should be an autonomous and self-regulating profession.

The Faculty feels that a suitable training program would be a "multiple entry", four-year baccalaureate program offered in a university. Advanced standing in such a program would be granted to nurses and others with appropriate training. (The Faculty also stated that a professional act and process for licensure must exist in conjunction with this training program).

The Faculty believes that midwives should be allowed to care for healthy females throughout their reproductive lives (particularly, of course, during pregnancy, delivery and early post-partum), and newborns up to six weeks of age. This care would include assessing the health of women and their newborns, ordering appropriate diagnostic tests, conducting deliveries on their own responsibility, prescribing certain medications, carrying out emergency procedures when medical help is unavailable, and providing counselling and contraceptive services. Midwives would also be responsible for consulting with, and referring patients to, physicians according to established criteria. Moreover, criteria for determining whether a pregnancy is suitable to be managed by a midwife (i.e., defining low-risk pregnancies) should also be established.

Midwives would be expected to practice independently - as colleagues of physicians and RNs as opposed to being supervised by them. They would be accountable primarily to their patients and to their professional association. Some midwives may choose to work in an institution, therefore, they would also have to abide by the regulations of the institution. Access to midwives would be either direct or by referral.

The Faculty alluded to births in the home as well as in hospitals and birthing centres, but offered no specifics on this issue.

The Faculty endorses the World Health Organization's definition for midwives which emphasizes their role as the expert in normal childbirth. They acknowledge the overlaps in practice with physicians, nurses, dieticians and social workers, but stated that midwives' services are "qualitatively, uniquely different" from services provided by these others to childbearing women. The Faculty feels that midwives could provide more integrated and wholistic care in contrast to the fragmented and often uncoordinated care given by these other professionals.

The Faculty also noted that some developed nations that have institutionalized midwifery services have incidence of perinatal and maternal mortality as low or lower than in Canada.

The University of Calgary Faculty of Nursing

The Faculty opposes designation; they support nurse-midwifery, though, and feel that such practitioners should be governed under the Nursing Profession Act.

The Faculty believes that health and education system budgets are too strained to accommodate a separate training program for midwives. Instead, they suggest that current baccalaureate programs for nurses could be extended and revised to provide adequate midwifery training to nurses. They added that nurse-midwives could practice collaboratively within the health care system in ways that accent particular practices of today's maternity nurses.

Alberta Health

Alberta Health recommends that midwifery be designated and regulated under the Health Disciplines Act to establish standards, procedures and controls to:

- protect the public from incompetent or unethical midwives;
- promote effective delivery of pre- and postnatal care and obstetrical services; and
- enable the public to exercise informed judgement and freedom of choice with respect to reproductive care.

Alberta Health made no specific comments on possible training programs. However, their brief contained the statement that "both nurse-midwives and direct-entry midwives be regulated under the same statute"; therefore, it appears the Department supports both direct entry and post-nursing training.

Alberta Health recommends that midwives provide the full range of obstetrical services, including prenatal care, maternal/family education, and delivery for normal (i.e., low-risk) pregnancies. The Department also stated that practice standards must be established for midwifery services provided in hospitals, homes, birthing centres and public health/home care programs; these standard must include clear protocols for identifying low-risk pregnancies.

If midwifery is designated, Alberta Health feels that three further concerns will be very important to address: appropriate and cost-effective reimbursement mechanisms; the availability of liability insurance for midwives; and the impact of legalized midwifery on medical and nursing personnel requirements.

Alberta Advanced Education

Advanced Education abstained on the question of whether midwifery should be designated. The only other comment made was that the two proposed streams of training (i.e., direct entry and post-RN training programs) are "plausible".

Alberta Family and Social Services

This Department stated only that it has no involvement with the occupation of midwifery, and therefore has no comments to offer regarding designation of the discipline.

Alberta Women's Secretariat

This agency supports the designation of midwifery for two reasons:

a) because of the apparent popular support for midwives, and
b) to ensure some measure of protection for clients of midwives.

The Secretariat also provided a basis for its position - a report from the Edmonton Midwifery Group that shows the extent to which midwives are being used in Edmonton. The report presents the outcomes of 697 planned home births in Edmonton between 1980 and 1987, 614 of which actually took place.

Alberta Advisory Council on Women's Issues (AACWI; para-government)

The AACWI did not submit an actual brief; however, they did submit a series of recommendations to Government regarding midwifery.

The AACWI believes women should have the choice of where and how to give birth, and choice of professional care giver during pregnancy, labor, and the post-partum period. Therefore, the Council recommended that the Alberta Government enact legislation to license midwives and to endorse the midwife as an independent practitioner whose scope of practice is consistent with the definition published by the World Health Organization. (The Council did not respond directly to the question of whether midwifery should be designated under the Health Disciplines Act). The AACWI rejects the view of midwives as physicians' assistants or nurses with expanded roles; instead, the Council feels that midwives should be autonomous professionals working co-operatively with other health professionals.

The Council also recommended that midwifery services be funded by the Government in order to ensure full integration of midwifery into the health care system.

APPENDIX 3:

LIST OF INDICATIONS FOR SPECIALIST CARE
IN THE NETHERLANDS

I. Indications based on the medical and/or obstetrical history

1. Diseases that either influence or are influenced by pregnancy, childbirth or puerperium.

1.1 Neurological diseases, such as epilepsy, subarachnoid haemorrhage, multiple sclerosis, brain tumours, displacement of an intervertebral disc and psychiatric disorders.

1.2 Medical disorders, such as pneumonectomy, lobectomy, active tuberculosis, bronchial asthma, cardiac disorders, Addison's disease, hypo- and hyperthyroidism, thrombosis and embolism.

1.3 Disease and pathology which influence or are influenced by pregnancy, essential hypertension, diabetes mellitus, arteriosclerosis, nephropathy, Rhesus sensitization, severe motor disorders (congenital or acquired), fractures of the pelvis, kyposcoliosis, sequelae of rickets, achondroplasia, previous operations or injuries to the uterus and vagina such as operations for prolapse, previous third-degree perineal tears, cervical conization, myomectomy, vesicovaginal and rectovaginal fistulae, and so on.

An age of 35 years or more for nulliparae and of 45 years or more for multiparae are considered to be an indication for delivery in hospital. Involuntary infertility of over three years' duration also consitutes a 'medical indication'.

2. Diseases that are purely obstetrical. Causes resulting from the obstetrical history that lead to a medical indication.

2.1 Habitual abortion (three or more), perinatal loss in the preceding pregnancy or a total of two perinatal losses, previous delivery between 16 and 37 weeks or a growth-retarded infant which required special care in the preceding pregnancy; if the preceding infant was born in bad condition, required resuscitation and/or has a handicap that can be ascribed to birth trauma; postpartum haemorrhage of 1000 ml or more and/or blood transfusion and/or manual removal of the placenta and/or shock, caesarean section, third-degree tear, abruptio placentae, symphysiolysis, severe pre-eclampsia requiring hospitalization in the preceding pregnancy, symptomatic pre-eclampsia, eclampsia, puerperal psychosis, thrombosis or embolism.

Indications that result from the first antenatal examination

Severe hypertension, proteinuria of 100 mg or more per 24 hours, pelvic tumours or severe anaemia.

III. Indications that may arise during the antenatal period

1. Obstetrical indications for admission to hospital in the first half of pregnancy

1.1 Severe haemorrhage.

1.2 Hyperemesis gravidarum with acetonuria.

1.3 Suspected molar pregnancy.

1.4 Abortion of a molar pregnancy.

1.5 Suspected extra-uterine pregnancy.

1.6 Ovarian cyst or tumour, requiring treatment.

2. Obstetrical indications for admission to hospital in the second half of pregnancy

2.1 Severe toxaemia (blood pressure of 150/95 on at least two separate occasions, proteinuria in excess of 100 mg per 24 hours, pre-eclampsia or eclampsia).

2.2 Blood-loss in the second half of pregnancy.

2.3 Onset of labour after the 22nd and before the 37th week (260 days).

2.4 Strongly suspected intra-uterine growth retardation.

2.5 Leakage of amniotic fluid.

2.6 Symptomatic polyhydramnios.

2.7 Pyelonephritis.

3. Obstetrical indications for admission to hospital arising in late pregnancy

3.1 Proven or probable fetal malformations detected by antenatal diagnosis.

3.2 Multiple pregnancy.

3.3 All malpositions, such as breech presentation, oblique position, transverse lie and so on, which are present after the 36th week.

3.4 A diagonal conjugate of less than 11 cm.

3.5 Overt disproportion.

3.6 Non-engaged head in the last four weeks of pregnancy in nulliparae.

3.7 Failed attempts to fit the fetal head into the pelvis in both nulliparae and multiparae.

3.8 Fetal death.

3.9 Unstable lie after the 36th week.

3.10 Rhesus sensitization.

3.11 Postmaturity, defined as more than 294 days for nulliparous and more than 301 days for multiparous women.

3.12 Abdominal surgery after the 26th week of gestation.

IV. Indications arising during labour and immediately postpartum

1. Indications for admission during labour

1.1 Malposition.

1.2 Signs of fetal distress, such as meconium-stained liquor, decelerations in fetal heart-rate.

1.3 Absence of labour 12 hours after rupture of the membranes.

1.4 Poor progress in second stage, with need for intervention.

1.5 Blood-loss during labour.

1.6 Abruptio placentae.

1.7 Vasa praevia.

2. Indications for admission in the immediate postpartum period

2.1 Any excessive blood-loss before or after delivery of the placenta that does not respond rapidly to treatment.

2.2 Retained placenta.

2.3 Third-degree perineal tear.

2.4 Separation of the symphysis pubis.

V. Indications in the puerperium

1. For the mother

1.1 Vulval haematoma, particularly when associated with disorders of micturition.

1.2 Serious puerperal infection with systemic illness, particularly when not responding to therapy.

1.3 Puerperal psychosis within 36 hours.

1.4 Thrombosis.

2. For the child

2.1 Growth-retarded and/or premature infant; a weight below 2000g always constitutes an indication; a weight between 2000 and 2500g virtually always constitutes an indication unless the general condition of the infant and facilities for adequate care and surveillance allow an exception to be made.

2.2 Any infant in excess of 2500g for reasons such as cyanosis, hypothermia, tracheo-oesophaegeal fistula, anal atresia, cleft palate which hinders feeding, jaundice within 24 hours or severe jaundice beyond that period.

VI. Those women who should be allowed to deliver at home

A woman is eligible for home delivery if:

1. She is healthy.

2. She shows no signs of toxaemia.

3. She has a singleton pregnancy with cephalic presentation and no cephalo-pelvic disproportion.

4. The fetal head is engaged in the last weeks of pregnancy or can at least be brought into contact with the pelvis.

5. There is no pathology (apart from abortion) in her obstetrical history.

6. She is a primigravida under 35 years of age or a multigravida under 45 years of age.

7. Labour starts spontaneously after the 36th week and before the 43rd week (45th week for multiparae).

Furthermore, social circumstances should be such that she has a separate bedroom with adequate heating, running water and easy access to a toilet, and that, in case of an emergency, she can be easily transported on a stretcher to the nearest hospital within one hour.

APPENDIX 4:

Edmonton Midwifery Group
Home Birth Statistics
1980-1989

Edmonton Midwifery Group is
Donna Gibbons, Noreen Walker, Sandy Pullin
Statistics compiled by Donna Gibbons.

Edmonton Midwifery Group Home Birth Statistics 1980-89

The Edmonton Midwifery Group is proud to present our statistics on home births from 1980, when we started attending births on our own, to the end of 1989.

Wherever possible we have included information on the women who were transferred to hospital. Because we don't have access to hospital delivery records, however, our totals don't always add up exactly. In addition, the statistics on length of labour may be distorted somewhat for it is often the women with the longest labours, particularly first time mothers, who are transferred. These statistics do NOT include the planned hospital births we attend as labour support.

Some terms we have used may need clarification. Parity refers to the number of times a women has given birth, therefore a P0 mother is a first time mother. Antepartum refers to the time before labour has begun, intrapartum is the time during labour, and postpartum follows delivery.

These numbers show how successful home birth can be. We are confident that we offer women a safe, important service - knowledge and support through one of life's major passages.

—Sandy, Noreen and Donna.

General Overview

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	Total
Planned home births	3	43	88	111	114	106	133	99	104	126	927
Completed home birth	3	39	74	97	104	93	114	90	93	120	827
	100%	90.7%	84.1%	87.4%	91.2%	87.7%	85.7%	90.9%	89.4%	95.2%	89.2%
Average age of mother	25.3	27.6	27.6	27.4	28.6	28.3	29	30	31	31	28.6
Age Range	24-37	20-37	20-36	18-36	20-42	20-42	18-38	21-42	20-42	20-43	
Parity - P0	0	10	34	41	35	38	36	21	21	28	264
											28.5%
P1	2	18	32	39	46	37	49	37	39	45	344
											37%
P2	1	10	14	21	20	19	26	25	26	35	197
											21%
P3	0	4	7	8	11	10	12	10	12	13	87
											9%
P4	0	1	1	2	1	1	4	4	4	4	22
											2%
P5	0	0	0	0	0	0	1	2	2	1	6
											0.7%
P6	0	0	0	0	0	0	0	0	0	1	1
Previous home birth	0	6	14	25	25	34	49	42	41	60	296
		14%	16%	23%	22%	32%	37%	42%	39%	48%	32%
Siblings present	3	24	47	49	54	56	60	56	54	69	472
											51%
Vacuum extraction	0	0	0	0	0	0	0	0	1	1	2
Forceps	0	1	1	4	2	8	5	3	4	1	29
											3.1%
C-sections	0	0	5	6	2	6	7	3	3	2	34
											3.7%
Maternal death	0	0	0	0	0	0	0	0	0	0	0
Intrauterine or infant death	0	1	0	0	2	1	2	1	1	1	9
											0.97%

Causes of Death

1981 - anencephalic baby
1984 - 2 babies with congenital heart defects
1985 - cord accident @ 42 weeks, stillbirth
1986 - anencephalic baby
1986 - meconium aspiration, pneumothorax
1987 - absent fetal heart @ 24 weeks, induced at 30 weeks
1988 - meconium aspiration
1989 - anencephalic baby

Length of Pregnancy

Only about 1 in 20 of our babies are actually born on their due date but averaging the always-early and the always-late moms brings us very close to 40 weeks.

# weeks	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	Total	%
<36 weeks	0	0	1@33 1@35	0	0	1@24 1@35	2@35	1@30 1@35	0	1@32	9	1.0%
36 weeks	0	0	0	2	0	2	1	1	2	0	8	9%
37 weeks	0	1	1	5	5	3	9	5	6	6	41	4.5%
38 weeks	0	5	13	15	16	9	12	11	11	13	105	11.6%
39 weeks	1	11	20	25	27	22	28	20	27	30	211	23.3%
40 weeks	1	18	30	31	36	33	41	24	35	45	294	32.5%
41 weeks	1	4	15	25	20	25	28	28	13	16	175	19.4%
42 weeks	0	2	3	6	3	8	5	6	10	12	55	6.1%
43 weeks	0	1	0	1	1	0	1	0	0	2	6	7%
Babies born on due date	0	4	6	7	3	6	10	2	10	3	51	5.6%
Average length in days	280	278	277	278	280	278	280	281	280	281	280	
											904 Pregnancies	

Average length of labour

First time mothers do have longer labours (averaging about eight hours), but all other labours average approximately five hours. Third stages at home take slightly longer than text book figures for hospital deliveries where a drug is given immediately after birth to stimulate contraction of the uterus and delivery of the placenta. Nature only takes about ten minutes longer.

	Para 0			Para 1			Para 2			Para 3			Para 4+		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
1981	7:30	1:21	0:18	6:42	0:21	0:14	7:54	0:22	0:20	4:24	0:17	0:13	6:45	0:31	0:19
1982	9:01	1:10	0:12	4:48	0:34	0:15	3:30	0:14	0:21	5:18	0:22	0:21	4:39	0:04	1:22
1983	7:48	1:11	0:15	5:18	0:33	0:14	4:56	0:15	0:14	4:48	0:29	0:13	4:46	0:06	0:12
1984	10:30	1:14	0:17	4:18	0:24	0:13	4:00	0:20	0:11	4:07	0:13	0:09	2:04	0:10	0:13
1985	5:55	1:02	0:13	5:12	0:37	0:11	4:12	0:17	0:10	4:48	0:14	0:11	7:50	0:31	0:19
1986	9:50	1:15	0:13	5:14	0:20	0:12	5:48	0:15	0:13	8:31	0:10	0:10	5:42	0:08	0:13
1987	8:01	0:30	0:14	6:46	0:30	0:11	5:39	0:12	0:12	3:56	0:16	0:10	3:23	0:06	0:15
1988	7:21	0:44	0:18	5:20	0:28	0:12	4:58	0:14	0:12	5:16	0:16	0:11	4:29	0:08	0:11
1989	10:45	1:24	0:13	4:40	0:21	0:12	4:43	0:17	0:12	3:59	0:11	0:11	4:00	0:15	0:11
Avg.	8:35	1:06	0:15	5:22	0:28	0:13	5:04	0:16	0:14	5:01	0:16	0:12	4:51	0:16	0:22

Edmonton Midwifery Group Home Birth Statistics 1980-89

How the mothers fared

Women who eat well during pregnancy usually gain 30-35 lbs. Although this may seem like a lot, when the result of good nutrition, it usually comes off quickly with breastfeeding. Episiotomies are kept to a minimum in our practice. The 8 recorded episiotomies from 1987-1989 all occurred in hospital transfers.

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	Total
Average weight gain (lbs)	32.3	30.4	33	33.1	35	33	34.2	33.5	34.8	33.5	
Artificial rupture of membranes after 6 cm.	2	7	2	15	20	18	23	10	14	12	123
Tears - 1°	0	16	34	30	12	10	13	17	28	11	171
Tears - 2°	0	0	0	0	33	17	30	22	22	45	23% 169
- 3°	0	0	0	2	1	0	3	0	0	2	18% 8
- 4°	0	0	0	1	0	1	0	0	1	0	1% 3
- labial	0	0	0	0	8	2	4	1	3	5	0.4% 23
Episiotomy	0	4	3	9	3	3	5	3	3	2	3% 35.
Oxytocin - post placenta	0	2	7	13	20	3	9	11	9	9	5% 83
I.V. - post placenta	0	0	5	5	5	0	2	2	2	1	22
Blood loss (avg)	203	279	326	347	341	225	243	289	245	200	
Blood loss 500 mL	0	1	4	10	12	4	9	10	5	4	59

Vaginal Births After Cesarean (VBAC)

Women planning VBACs continue to make up a significant part of our practice. This year, all of our VBAC clients had vaginal births, 10 with labours under five hours long. This is a count of both home and planned hospital VBACs.

	1984	1985	1986	1987	1988	1989	Total	
Planned hospital	0	0	6	4	8	4	22	
Planned home	1	2	10	14	19	17	63	
-transfers	0	0	0	4	6	1	11	
Total home and hospital	1	2	16	18	27	21	85	
Successful	1	2	16	17	21	21	78	or 92%

Average length of labour:

	1984-1987	1988	1989	Average
1st stage	9:19	9:21	4:33	7:44
2nd stage	0:51	0:45	0:39	0:45
3rd stage	0:13	0:11	0:12	0:12

The Babies

One question we are often asked is "What if the cord is around the baby's neck?" It happens in nearly one quarter of our births, with little detriment to either mother or baby. 25% of the babies in 1989 were over 4,000 grams (about 9 lbs). The largest was 11 lbs 10 oz. One baby this year was born "in the caul" - with membranes intact.

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	Total	%
Sex - male	2	22	51	61	63	56	56	57	54	61	483	52.6%
female	1	21	37	50	51	50	73	41	47	65	436	47.4%
Apgar - 1 min. (avg.)	9	8.1	8.1	8	8.5	8.3	8.8	9	8	9		
Apgar - 5 min. (avg.)	9.7	9.6	9.6	9.5	9.7	9.7	9.7	9.6	9	9.6		
Suction	1	13	29	40	56	48	59	50	57	51	404	44.0%
Oxygen	0	6	15	15	26	20	19	17	24	25	167	18.2%
Average weight (grams)	4292	3582	3548	3569	3944	3550	3615	3641	3697	3664		
Meconium in fluid	0	10	11	14	19	23	26	13	16	22	154	16.8%
Cord around neck	0	5	13	22	19	27	26	28	26	40	206	22.4%
X 2	0	0	4	1	4	2	3	1	6	10	31	3.4%
X 3	0	2	0	2	0	0	0	1	0	4	9	1.0%
over shoulder/body	0	0	0	0	0	0	0	0	2	4	6	.7%
cut before delivery	0	0	0	0	2	2	1	0	0	0	5	.5%
true knot	0	0	0	1	1	2	0	1	2	3	10	1.1%

Antepartum Transfers

Approximately 4% of our clients are transferred prenatally for complications such as breeches, twins, pre-eclampsia, or premature labour. The number of breech births has decreased over the years as our skill in external version has increased, and cases of pre-eclampsia have fallen as our clients' nutrition and understanding of the importance of rest have improved.

Over half of these clients have had vaginal births, including one who was previously sectioned for a breech.

Year	#	Reason	Result
1980	0		
1981	1	Anencephalic baby.	Augment, vaginal delivery. Baby died at 1.5 hours.
1982	7	4 pre-eclampsia	2 spontaneous labour and deliveries. 2 c-sections
		2 breech	1 spontaneous labour and delivery. 1 c-section.
		1 premature labour	Spontaneous delivery.
1983	7	1 pre-eclampsia	Spontaneous labour and delivery.
		1 set of twins, breech	Elective c-section.
		5 breeches	2 vaginal deliveries. 3 c-sections.
1984	3	1 premature labour	Vaginal delivery.
		1 breech	Spontaneous labour and delivery.
		1 transverse	C-section
1985	5	2 breech	1 c-section after failure to progress. 1 c-section with no trial of labour.
		1 pre-eclampsia	Induction, c-section.
		1 absent FH	Induction, spontaneous delivery of stillborn baby.
		1 partial placental abruption at 24 wk	Spontaneous vaginal delivery.
1986	10	1 placenta previa	C-section.
		1 twins	C-section.
		5 breech	3 spontaneous vaginal deliveries. 1 forceps 1 c-section.
		1 premature labour.	Spontaneous labour and delivery.
		1 premature rupture of membranes	Spontaneous labour and delivery.
		1 post-dates, 42+ weeks	Induction, vaginal delivery.
1987	4	2 breech	1 successful VBAC. 1 c-section.
		1 post-dates, 42+ weeks.	Elective induction.
		1 intrauterine death at 24 weeks	Induced at 30 weeks.
1988	3	1 breech	Failure to progress. Repeat c-section.
		1 pre-eclampsia	Bed rest for three weeks., spontaneous delivery.
		1 anemia	Spontaneous labour, forceps assisted delivery.
1989	2	1 premature labour	Spontaneous delivery of anencephalic baby.
		1 twins	Failure to progress. C-section.
Total	42 or 4.5%		

Intra-partum Transfers

First time mothers (PO) who fail to progress in labour due to the baby's position tend to be our most common intra-partum transfers. We no longer automatically transfer women with ruptured membranes who do not go into labour within 12 hours. New research shows that the risk of infection when membranes rupture is considerably lowered when women are not examined vaginally until labour is well established. So, we watch and wait.

Year	#	Reason	Result
1980	0		
1981	1	PO. failure to progress	Augment. spontaneous delivery.
1982	7	3 prolonged ruptured membranes	3 augment. vaginal delivery.
		2 PO. meconium staining	1 spontaneous delivery.
			1 forceps delivery.
		2 failure to progress	2 augment. c-section.
1983	8	3 prolonged ruptured membranes	1 augment. spontaneous delivery.
			2 augment. forceps.
		1 failure to progress	1 c-section - scar tissue over cervix.
		4 unrecorded	
1984	5	1 prolonged ruptured membranes	Augment. vaginal birth.
		1 posterior arrest at 9 cm.	Forceps.
		2 PO. failure to progress	1 spontaneous delivery.
			1 c-section.
		1 prolonged latent phase.	Augment. vaginal delivery.
1985	8	3 PO. posterior arrest	3 augments. forceps.
		2 PO. failure to progress	1 augment. vaginal delivery.
			1 c-section.
		1 PO. failure to progress	C-section for brow presentation.
		1 PO. second stage arrest	Forceps.
		1 PO. fetal distress in early labour	C-section.
1986	8	3 PO. failure to progress	2 c-sections.
			1 demerol. ARM. vaginal delivery - no episiotomy.
		1 failure to progress	Delivered on arrival at hospital.
		1 prolonged ruptured membranes.	1 c-section.
		3 prolonged second stage	2 forceps.
			1 augment and forceps.
1987	5	1 PO. posterior arrest	C-section.
		1 VBAC. failure to progress	C-section.
		2 second stage arrest	2 forceps.
		1 decreased FHR in second stage	Forceps.
1988	8	1 PO. meconium in fluid at 4 cm.	Spontaneous delivery.
		1 VBAC. failure to progress at 2 cm.	Repeat section.
		1 decreased FHR at 9 cm.	Forceps.
		1 2nd stage posterior arrest.	Delivery on arrival at hospital.
		1 VBAC. second stage arrest.	Repeat section.
		2 PO. meconium staining,	
		2nd stage decreased FHR	2 forceps.
		1 2nd stage decreased FHR	Vacuum extraction.
1989	4	1 VBAC. posterior arrest at 9 cm	Augment. spontaneous delivery.
		2 PO. 2nd stage posterior arrest.	1 vacuum extraction.
			1 forceps.
		1 PO. failure to progress at 4 cm.	C-section
Total	54 or 5.8%		

Post-partum Transfers

Post-partum hemorrhage, the complication doctors often use to deter women from having home births, has only caused us to transfer seven women in ten years.

Year	#	Reason	Result
1980	0		
1981	0		
1982	0		
1983	2	2 post-partum hemorrhage	1 blood transfusion. 1 transfusion. D & C for retained piece of placenta.
1984	1	Post-partum hemorrhage	1 transfusion. D & C for retained piece of placenta.
1985	0		
1986	1	Post-partum hemorrhage and to be with transferred baby.	
1987	1	Paravaginal hematoma	D & C. drainage of hematoma.
1988	2	Repair of tear, to be with baby. Post-partum hemorrhage.	IV and observation for 24 hours.
1989	0		
Total	7 or 0.8%		

Baby Transfers

Only 17 babies have been transferred over the 10 years of our practice, 8 of whom had congenital problems.

Year	#	Reason	Result
1980	0		
1981	0		
1982	1	Meconium aspiration.	Observation for 24 hrs.
1983	2	On day 2 for fever. Meconium aspiration.	Antibiotics and observation for 48 hrs. Observation for 48 hrs.
1984	2	At 48 hrs for fever.. At 45 min for poor colour and respirations.	Died next morning from congenital heart defect. Died at 2 mo. following heart surgery.
1985	3	At 3 hrs for circumoral cyanosis. Spinal abnormality. At 5 hr for meconium aspiration.	Observation overnight. Surgery performed same day. Observation for 72 hrs.
1986	2	To NICU for pneumothorax. Respiratory difficulties.	Died at 48 hrs. Congenital respiratory defect.
1987	1	Hernia of abdominal contents through navel (omphalocele)	Surgery performed same day.
1988	4	Meconium aspiration. Meconium aspiration. Extra digits, hypospadias, cyanosis. At 12 hours for cyanosis.	Died at 3 weeks. Assessment, observation. In hospital for 4 hours. Transposition of great vessels, surgery performed on day 3.
1989	2	At 20 hours for apneic spells. At 4 hours for cyanosis.	Assessment, observation. Hyaline membrane disease. Observation.
Total	17		